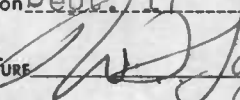



VS A15 (4)  
15M 10/57

10710 **CERTIFICATE OF DEATH**

10690

Reg. Dist. No. 302

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>  |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                                     |  | b. COUNTY<br><b>Washington</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  | c. LENGTH OF STAY IN lb<br><b>5 Days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>031/Kangansville Hagerstown</b>                                   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash County Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>6 Hager Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ANNA</b>  |  | First<br><b>MAE</b>  |  | Middle<br><b>ALLEN</b>   |  | Last  |  |
| 4. DATE OF DEATH<br><b>September 18 1959</b>   |  | Month  |  | Day  |  | Year  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 12 1880</b>  |  |
| 9. AGE (In years last birthday)<br><b>78</b>   |  | IF UNDER 1 YEAR<br>Months<br><b>78</b>   |  | IF UNDER 24 HRS.<br>Days<br><b>78</b>  |  | Hours<br><b>78</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>W. Va</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas LeDane</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosella Pearl</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Lawrence Glover Sunrise Drive</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic congestive heart failure</b><br><b>420.0</b> DUE TO <b>arteriosclerotic, hypertensive and</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>rheumatic heart disease</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 years</b><br><b>12 years</b><br><b>unknown</b>               |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Sept. 4</b> , 19 <b>47</b> , to <b>Sept. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 17</b> , 19 <b>59</b> , and that death occurred at <b>8:20 A.M.</b> , from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br>  |  | M.D. <b>100 Professional Arts Bldg. 9/19/59</b>  |  | ADDRESS (Street, city or town, state)<br><b>Hagerstown Maryland</b>  |  | DATE SIGNED<br><b>9/19/59</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>William T. Layman</b>  |  | <b>Hagerstown</b>  |  | <b>Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>9/20/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Mills Cemetery Falling Waters Berkley Co.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>W. Va.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>  |  | ADDRESS<br><b>Hagerstown Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>SEP 25 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br> |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10697

Reg. Dist. No.

10711

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |   | c. LENGTH OF STAY IN 1b<br><u>35 Yrs</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>725 Sunset Ave</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HOMER</u> Middle <u>CLEVELAND</u> Last <u>AMOS</u>   |   | 4. DATE OF DEATH<br>Month <u>September</u> Day <u>26</u> Year <u>1959</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                | 8. DATE OF BIRTH<br><u>May 5 1887</u>              |
| 9. AGE (In years last birthday)<br><u>72 yrs.</u>  |   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Plumber Retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-----</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Waynesburg Greene Co Pa</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Andrew Amos</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>No Record</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>Yes</u> <u>W.W.# 1</u>   |   | 16. SOCIAL SECURITY NO.<br><u>217-32-5625</u>  |  |
| 17. INFORMANT<br><u>Andrew A. Amos</u>   |   | Address<br><u>1025 Rose Hill Ave</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Cardio Vascular Dis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u><br>(c) <u>  </u> DUE TO <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)               |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |  |  |
| ACTUAL SIGNATURE <u>A. E. Smith</u>  |   | DATE SIGNED <u>9/28/59</u>   |  |
| EXAMINER'S NAME (Type)<br><u>ATRENDIT TO</u>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 22b. DATE THEREOF<br><u>9/29/59</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Wash Co Md</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Andrew K. Coffman</u>   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 2 '59</u>   |  |
| ADDRESS<br><u>Hagerstown Md.</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |

TE 5201  
20712801

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

10762

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Adams</u> ✓           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fayetteville</u> 75x-3   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>   |                                    | d. STREET ADDRESS <u>R.F.D. # 1</u>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Benjamin A. Barney</u>   |                                    | 4. DATE OF DEATH Month Day Year <u>September 19 1959</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>white</u>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 16, 1872</u>                                      |
| 9. AGE (In years last birthday) <u>87</u> yrs.  |                                    | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Independence, New York</u>   |                                    | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Jonathan O. Barney</u>   |                                    | 14. MOTHER'S MAIDEN NAME <u>Lillie Dexter</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| INFORMANT Address <u>Mrs. Marion Howard Fayetteville, Rt. 1 Pa.</u>   |                                    |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Heart failure</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis - gen debility</u> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <u>15 mos</u><br><u>5 yrs</u> |                                    | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                                    | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Aug 1</u> , 1958 to <u>Sept 19</u> , 1959, that I last saw the deceased alive on <u>Sept 4</u> , 1959, and that death occurred at <u>7 A.</u> M, from the causes and on the date stated above.   |                                    |  |  |
| ACTUAL SIGNATURE <u>Max E Byrkit</u> M.D.   |                                    | DATE SIGNED <u>9-19-59</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Max E Byrkit</u>   |                                    | <u>Williamsport Md</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>9/22/1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Canisteo Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Steuben Co., New York</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ronger</u>  |                                    | ADDRESS <u>Hagerstown, Md.</u>   |  |
| 24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>  |                                    | 24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Kiana</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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[illegible]



10713

CERTIFICATE OF DEATH

10699

Reg. Dist. No. 302

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  |   |  | e. STREET ADDRESS<br><b>419 George Street</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LISA</b> Middle <b>KOREN</b> Last <b>BLEVINS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>14</b> Year <b>19 59</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 2, 1958</b>                                     |  |
| 9. AGE (In years last birthday) yrs. <b>11</b>   |  | IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b> |  | IF UNDER 24 HRS.<br>Hours <b>11</b> Min. <b>11</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown, Maryland</b>       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Archie Blevins</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Shirley Lewis</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. Archie Blevins</b> Address <b>Hagerstown, Maryland</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br>DUE TO <b>Dehydration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Dysenteritis</b><br>DUE TO <b>Dysenteritis</b><br>(c) <b>Dysenteritis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hr</b><br><b>4 days</b><br><b>8 days</b>   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>9/11/1959</b> , to <b>9/14/1959</b> , that I last saw the deceased alive on <b>9/14/1959</b> , and that death occurred at <b>1:20 A.M.</b> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Richard A. Young</b> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <b>101 King Street Hagerstown, Md.</b>   |  |  |  |
| DATE SIGNED <b>9/14/59</b>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Richard A. Young</b>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>9/16/1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Rouzer Funeral Home</b>   |  |   |  | ADDRESS<br><b>Hagerstown, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 17 '59</b>                                   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hays</b>  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

2081223XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BATHINGORE, ME

|                           |  |                              |  |                            |  |                           |  |                            |  |
|---------------------------|--|------------------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED       |  | 2. SEX                       |  | 3. AGE                     |  | 4. DATE OF BIRTH          |  | 5. PLACE OF BIRTH          |  |
| JAMES H. HARRIS           |  | Male                         |  | 65                         |  | 1890                      |  | Maine, U.S.A.              |  |
| 6. DATE OF DEATH          |  | 7. PLACE OF DEATH            |  | 8. CAUSE OF DEATH          |  | 9. MANNER OF DEATH        |  | 10. SIGNATURE OF REGISTRAR |  |
| 1955                      |  | Home                         |  | Heart Disease              |  | Natural                   |  | [Signature]                |  |
| 11. SIGNATURE OF DECEASED |  | 12. SIGNATURE OF NEXT OF KIN |  | 13. SIGNATURE OF PHYSICIAN |  | 14. SIGNATURE OF MINISTER |  | 15. SIGNATURE OF CORONER   |  |
| [Signature]               |  | [Signature]                  |  | [Signature]                |  | [Signature]               |  | [Signature]                |  |

MAINE STATE DEPARTMENT OF HEALTH - BATHINGORE, ME



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10714  
CERTIFICATE OF DEATH

10700

Reg. Dist. No.

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>03</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NORMAN</b> Middle <b>JACOB</b> Last <b>BOWERS</b>   |                                     | 4. DATE OF DEATH<br>Month <b>SEPT.</b> Day <b>29</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/8/1874</b>   |
| 9. AGE (In years lost birthday)<br><b>84</b> yrs.   |                                     | 10. IF UNDER 1 YEAR<br>Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.  | 11. IF UNDER 24 HRS.<br>Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED FARMER</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TENANT FARM</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>GEORGE BOWERS</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>SUSAN BAKER</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  |
| 17. INFORMANT<br><b>MRS. MILDRED MORRISON</b>   |                                     | 18. ADDRESS<br><b>HAGERSTOWN MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>600.0</b> DUE TO <b>fractured 5th rib (multiple rib fracture)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pyelonephritis - left &amp; with renal calculi</b><br>(c) <b>renal calculi</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign prostate</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>uraf.</b> |                                     |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |
| 20c. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20e. (City or town)   |                                     | 20f. (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Sept 7, 1959</b> to <b>Sept 29, 1959</b> , that I last saw the deceased alive on <b>Sept 28, 1959</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>217 W. Washington St.</b> DATE SIGNED <b>9/30/59</b>   |                                     |  |  |
| ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D. <b>217 W. Washington St.</b>   |                                     |  |  |
| PHYSICIAN'S NAME (Type) <b>Edward W. Ditto</b> M.D. <b>Hagerstown, Maryland</b>   |                                     |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 22b. DATE THEREOF<br><b>10/2/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MANOR CHURCH CEM.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON CO. MD.</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Morrison, Hagerstown, Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>OCT 5 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles A. ...</b>                          |

CENTRAL OF DEATH

10014

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON COUNTY HOSPITAL

HOMER

HALL

RETIRED LABORER

GEORGE BOWERS

NO

ROBERT EDWARD ROBINSON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

## CERTIFICATE OF DEATH

Reg. Dist. No.

10701

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>9 HOURS</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASH. CO. HOSPITAL</u>   |                                  | e. STREET ADDRESS<br><u>KNOXVILLE MD. R.I.</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>JAMES</u> <u>HOWARD</u> <u>CARTER</u>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPTEMBER</u> <u>16</u> <u>1959</u>  |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>OCTOBER-12-1892</u> |
| 9. AGE (In years last birthday)<br><u>66</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>11</u> <u>4</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED ENGINEER</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>B.O.R.R.CO.</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>VARROWSBURG WASH.CO. MD. U.S.A.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>ISAAC CARTER</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>MARY HOFFMASTER</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>(If yes, give war or dates of service)</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>705-07-1574</u>   |  |
| 17. INFORMANT<br><u>MRS. ELLEN M. CARTER</u>  |                                  | Address<br><u>KNOXVILLE MD. R.I.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u><br><u>443X</u> DUE TO <u>(middle cerebral artery)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Hypertensive Cardiovascular Disease</u><br>(c) <u>Diabetes Mellitus</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hr</u><br><u>10 yr</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Diabetes Mellitus</u>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Sept 15, 1959</u> to <u>Sept 16, 1959</u> , that I last saw the deceased alive on <u>Sept 15, 1959</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE<br><u>Edward W. Dittus III</u>   |                                  | ADDRESS (Street, city or town, state)<br><u>212 W. Washington St. Washington, D.C.</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>Edward W. Dittus III</u>  |                                  | DATE SIGNED<br><u>Sept 17, 1959</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 22b. DATE THEREOF<br><u>SEPT. 18, 1959</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>BROWNSVILLE CEMETERY</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>BROWNSVILLE WASH. CO. MD.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John H. West</u>   |                                  | ADDRESS<br><u>BOONSBORO MD.</u>   |  |
| 24a. REC'D BY REGISTRAR<br><u>SEP 21 59</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>John H. West</u>   |  |



10763

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown R # 2</b><br>c. LENGTH OF STAY IN 1b<br><b>5 Mos</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Gateway Conv. Home</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b><br>d. STREET ADDRESS<br><b>652 No Prospect St</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>WARREN SOLOMON CLOUSTON</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept 19 1959</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>March 13 1908</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>51</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Coal Miner</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Weaver Randolph Co</b>        |  |
| 13. FATHER'S NAME<br><b>Hugh Clouston</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Phillips</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>236-63-9090</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs Eva Ridenour 652 No Prospect St</b>        |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arterio-sclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 yrs.</b><br><b>3 mos.</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |  |   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  |
| 20f. (City or town) (County) (State)  |  |   |  | 20g. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>June 6</b> , 19 <b>59</b> , to <b>Sept 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 9</b> , 19 <b>59</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>159 W. Washington St. Hagerstown, Md. 9/19/59</b>   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Philip J. Hirshman</b>   |  |   |  | PHYSICIAN'S NAME (Type)<br><b>Philip J. Hirshman, M.D.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>9/21/59</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Long Meadows Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Paramount Wash Co Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>SEP 25 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
|---------------------------|--|------------------|--|-------------|--|------------------|--|------------------|--|--------------------------|--|------------------------|--|---------------------------|--|---------------------------|--|
| 1. Name of deceased       |  | 2. Sex           |  | 3. Age      |  | 4. Date of birth |  | 5. Date of death |  | 6. Place of death        |  | 7. Cause of death      |  | 8. Signature of physician |  | 9. Signature of registrar |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 10. Name of informant     |  | 11. Relationship |  | 12. Address |  | 13. City         |  | 14. State        |  | 15. Zip                  |  | 16. Date of filing     |  | 17. Registrar's signature |  | 18. Registrar's title     |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 19. Name of funeral home  |  | 20. Address      |  | 21. City    |  | 22. State        |  | 23. Zip          |  | 24. Date of funeral      |  | 25. Name of minister   |  | 26. Address               |  | 27. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 28. Name of cemetery      |  | 29. Address      |  | 30. City    |  | 31. State        |  | 32. Zip          |  | 33. Date of burial       |  | 34. Name of minister   |  | 35. Address               |  | 36. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 37. Name of hospital      |  | 38. Address      |  | 39. City    |  | 40. State        |  | 41. Zip          |  | 42. Date of admission    |  | 43. Name of physician  |  | 44. Address               |  | 45. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 46. Name of doctor        |  | 47. Address      |  | 48. City    |  | 49. State        |  | 50. Zip          |  | 51. Date of examination  |  | 52. Name of physician  |  | 53. Address               |  | 54. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 55. Name of nurse         |  | 56. Address      |  | 57. City    |  | 58. State        |  | 59. Zip          |  | 60. Date of examination  |  | 61. Name of physician  |  | 62. Address               |  | 63. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 64. Name of pharmacist    |  | 65. Address      |  | 66. City    |  | 67. State        |  | 68. Zip          |  | 69. Date of examination  |  | 70. Name of physician  |  | 71. Address               |  | 72. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 73. Name of undertaker    |  | 74. Address      |  | 75. City    |  | 76. State        |  | 77. Zip          |  | 78. Date of examination  |  | 79. Name of physician  |  | 80. Address               |  | 81. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 82. Name of funeral home  |  | 83. Address      |  | 84. City    |  | 85. State        |  | 86. Zip          |  | 87. Date of examination  |  | 88. Name of physician  |  | 89. Address               |  | 90. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 91. Name of cemetery      |  | 92. Address      |  | 93. City    |  | 94. State        |  | 95. Zip          |  | 96. Date of examination  |  | 97. Name of physician  |  | 98. Address               |  | 99. City                  |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 100. Name of doctor       |  | 101. Address     |  | 102. City   |  | 103. State       |  | 104. Zip         |  | 105. Date of examination |  | 106. Name of physician |  | 107. Address              |  | 108. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 109. Name of nurse        |  | 110. Address     |  | 111. City   |  | 112. State       |  | 113. Zip         |  | 114. Date of examination |  | 115. Name of physician |  | 116. Address              |  | 117. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 118. Name of pharmacist   |  | 119. Address     |  | 120. City   |  | 121. State       |  | 122. Zip         |  | 123. Date of examination |  | 124. Name of physician |  | 125. Address              |  | 126. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 127. Name of undertaker   |  | 128. Address     |  | 129. City   |  | 130. State       |  | 131. Zip         |  | 132. Date of examination |  | 133. Name of physician |  | 134. Address              |  | 135. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 136. Name of funeral home |  | 137. Address     |  | 138. City   |  | 139. State       |  | 140. Zip         |  | 141. Date of examination |  | 142. Name of physician |  | 143. Address              |  | 144. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 145. Name of cemetery     |  | 146. Address     |  | 147. City   |  | 148. State       |  | 149. Zip         |  | 150. Date of examination |  | 151. Name of physician |  | 152. Address              |  | 153. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 154. Name of doctor       |  | 155. Address     |  | 156. City   |  | 157. State       |  | 158. Zip         |  | 159. Date of examination |  | 160. Name of physician |  | 161. Address              |  | 162. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 163. Name of nurse        |  | 164. Address     |  | 165. City   |  | 166. State       |  | 167. Zip         |  | 168. Date of examination |  | 169. Name of physician |  | 170. Address              |  | 171. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 172. Name of pharmacist   |  | 173. Address     |  | 174. City   |  | 175. State       |  | 176. Zip         |  | 177. Date of examination |  | 178. Name of physician |  | 179. Address              |  | 180. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 181. Name of undertaker   |  | 182. Address     |  | 183. City   |  | 184. State       |  | 185. Zip         |  | 186. Date of examination |  | 187. Name of physician |  | 188. Address              |  | 189. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 190. Name of funeral home |  | 191. Address     |  | 192. City   |  | 193. State       |  | 194. Zip         |  | 195. Date of examination |  | 196. Name of physician |  | 197. Address              |  | 198. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 199. Name of cemetery     |  | 200. Address     |  | 201. City   |  | 202. State       |  | 203. Zip         |  | 204. Date of examination |  | 205. Name of physician |  | 206. Address              |  | 207. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 208. Name of doctor       |  | 209. Address     |  | 210. City   |  | 211. State       |  | 212. Zip         |  | 213. Date of examination |  | 214. Name of physician |  | 215. Address              |  | 216. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 217. Name of nurse        |  | 218. Address     |  | 219. City   |  | 220. State       |  | 221. Zip         |  | 222. Date of examination |  | 223. Name of physician |  | 224. Address              |  | 225. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 226. Name of pharmacist   |  | 227. Address     |  | 228. City   |  | 229. State       |  | 230. Zip         |  | 231. Date of examination |  | 232. Name of physician |  | 233. Address              |  | 234. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 235. Name of undertaker   |  | 236. Address     |  | 237. City   |  | 238. State       |  | 239. Zip         |  | 240. Date of examination |  | 241. Name of physician |  | 242. Address              |  | 243. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 244. Name of funeral home |  | 245. Address     |  | 246. City   |  | 247. State       |  | 248. Zip         |  | 249. Date of examination |  | 250. Name of physician |  | 251. Address              |  | 252. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 253. Name of cemetery     |  | 254. Address     |  | 255. City   |  | 256. State       |  | 257. Zip         |  | 258. Date of examination |  | 259. Name of physician |  | 260. Address              |  | 261. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 262. Name of doctor       |  | 263. Address     |  | 264. City   |  | 265. State       |  | 266. Zip         |  | 267. Date of examination |  | 268. Name of physician |  | 269. Address              |  | 270. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 271. Name of nurse        |  | 272. Address     |  | 273. City   |  | 274. State       |  | 275. Zip         |  | 276. Date of examination |  | 277. Name of physician |  | 278. Address              |  | 279. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 280. Name of pharmacist   |  | 281. Address     |  | 282. City   |  | 283. State       |  | 284. Zip         |  | 285. Date of examination |  | 286. Name of physician |  | 287. Address              |  | 288. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 289. Name of undertaker   |  | 290. Address     |  | 291. City   |  | 292. State       |  | 293. Zip         |  | 294. Date of examination |  | 295. Name of physician |  | 296. Address              |  | 297. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 298. Name of funeral home |  | 299. Address     |  | 300. City   |  | 301. State       |  | 302. Zip         |  | 303. Date of examination |  | 304. Name of physician |  | 305. Address              |  | 306. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 307. Name of cemetery     |  | 308. Address     |  | 309. City   |  | 310. State       |  | 311. Zip         |  | 312. Date of examination |  | 313. Name of physician |  | 314. Address              |  | 315. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 316. Name of doctor       |  | 317. Address     |  | 318. City   |  | 319. State       |  | 320. Zip         |  | 321. Date of examination |  | 322. Name of physician |  | 323. Address              |  | 324. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 325. Name of nurse        |  | 326. Address     |  | 327. City   |  | 328. State       |  | 329. Zip         |  | 330. Date of examination |  | 331. Name of physician |  | 332. Address              |  | 333. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 334. Name of pharmacist   |  | 335. Address     |  | 336. City   |  | 337. State       |  | 338. Zip         |  | 339. Date of examination |  | 340. Name of physician |  | 341. Address              |  | 342. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 343. Name of undertaker   |  | 344. Address     |  | 345. City   |  | 346. State       |  | 347. Zip         |  | 348. Date of examination |  | 349. Name of physician |  | 350. Address              |  | 351. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 352. Name of funeral home |  | 353. Address     |  | 354. City   |  | 355. State       |  | 356. Zip         |  | 357. Date of examination |  | 358. Name of physician |  | 359. Address              |  | 360. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 361. Name of cemetery     |  | 362. Address     |  | 363. City   |  | 364. State       |  | 365. Zip         |  | 366. Date of examination |  | 367. Name of physician |  | 368. Address              |  | 369. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 370. Name of doctor       |  | 371. Address     |  | 372. City   |  | 373. State       |  | 374. Zip         |  | 375. Date of examination |  | 376. Name of physician |  | 377. Address              |  | 378. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 379. Name of nurse        |  | 380. Address     |  | 381. City   |  | 382. State       |  | 383. Zip         |  | 384. Date of examination |  | 385. Name of physician |  | 386. Address              |  | 387. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 388. Name of pharmacist   |  | 389. Address     |  | 390. City   |  | 391. State       |  | 392. Zip         |  | 393. Date of examination |  | 394. Name of physician |  | 395. Address              |  | 396. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 397. Name of undertaker   |  | 398. Address     |  | 399. City   |  | 400. State       |  | 401. Zip         |  | 402. Date of examination |  | 403. Name of physician |  | 404. Address              |  | 405. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 406. Name of funeral home |  | 407. Address     |  | 408. City   |  | 409. State       |  | 410. Zip         |  | 411. Date of examination |  | 412. Name of physician |  | 413. Address              |  | 414. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 415. Name of cemetery     |  | 416. Address     |  | 417. City   |  | 418. State       |  | 419. Zip         |  | 420. Date of examination |  | 421. Name of physician |  | 422. Address              |  | 423. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 424. Name of doctor       |  | 425. Address     |  | 426. City   |  | 427. State       |  | 428. Zip         |  | 429. Date of examination |  | 430. Name of physician |  | 431. Address              |  | 432. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 433. Name of nurse        |  | 434. Address     |  | 435. City   |  | 436. State       |  | 437. Zip         |  | 438. Date of examination |  | 439. Name of physician |  | 440. Address              |  | 441. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 442. Name of pharmacist   |  | 443. Address     |  | 444. City   |  | 445. State       |  | 446. Zip         |  | 447. Date of examination |  | 448. Name of physician |  | 449. Address              |  | 450. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 451. Name of undertaker   |  | 452. Address     |  | 453. City   |  | 454. State       |  | 455. Zip         |  | 456. Date of examination |  | 457. Name of physician |  | 458. Address              |  | 459. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 460. Name of funeral home |  | 461. Address     |  | 462. City   |  | 463. State       |  | 464. Zip         |  | 465. Date of examination |  | 466. Name of physician |  | 467. Address              |  | 468. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 469. Name of cemetery     |  | 470. Address     |  | 471. City   |  | 472. State       |  | 473. Zip         |  | 474. Date of examination |  | 475. Name of physician |  | 476. Address              |  | 477. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 478. Name of doctor       |  | 479. Address     |  | 480. City   |  | 481. State       |  | 482. Zip         |  | 483. Date of examination |  | 484. Name of physician |  | 485. Address              |  | 486. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 487. Name of nurse        |  | 488. Address     |  | 489. City   |  | 490. State       |  | 491. Zip         |  | 492. Date of examination |  | 493. Name of physician |  | 494. Address              |  | 495. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 496. Name of pharmacist   |  | 497. Address     |  | 498. City   |  | 499. State       |  | 500. Zip         |  | 501. Date of examination |  | 502. Name of physician |  | 503. Address              |  | 504. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 505. Name of undertaker   |  | 506. Address     |  | 507. City   |  | 508. State       |  | 509. Zip         |  | 510. Date of examination |  | 511. Name of physician |  | 512. Address              |  | 513. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 514. Name of funeral home |  | 515. Address     |  | 516. City   |  | 517. State       |  | 518. Zip         |  | 519. Date of examination |  | 520. Name of physician |  | 521. Address              |  | 522. City                 |  |
|                           |  |                  |  |             |  |                  |  |                  |  |                          |  |                        |  |                           |  |                           |  |
| 523. Name of cemetery     |  | 524. Address     |  | 525. City   |  | 526. State       |  |                  |  |                          |  |                        |  |                           |  |                           |  |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

CERTIFICATE OF DEATH

Reg. Dist. No.

10703

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>   |                                  | c. LENGTH OF STAY IN 1b <b>2 YRS.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GATEWAY CONV. HOME</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>EVA</b> First Middle Last <b>FRANCES CURREY</b>   |                                  | 4. DATE OF DEATH <b>SEPTEMBER 23</b> 19 <b>59</b> Month Day Year   |   |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10/14/1873</b>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>             |
| 13. FATHER'S NAME <b>PHILIP H. BLOOM</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>MARY RECK</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                                  | 16. SOCIAL SECURITY NO. <b>215-14-1583</b>   |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                                  | 18. MOTHER'S MAIDEN NAME <b>MARY RECK</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause preceding for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b><br>170X DUE TO <b>with Metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Metastasis</b><br>DUE TO (c) <b>with Metastasis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>July 30, 1959</b> to <b>Sept 23, 1959</b> , that I last saw the deceased alive on <b>Sept 22, 1959</b> and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>9/25/59</b>  |   |
| PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>  | 22b. DATE THEREOF <b>9/25/59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>UNION BRIDGE CEM.</b>  | 22d. LOCATION (City, town, or county) (State) <b>UNION BRIDGE MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b> ADDRESS <b>Hagerstown Md</b>   |                                  | 24. REC'D BY REGISTRAR <b>SEP 28 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |   |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1934

WASHINGTON

MARY ANN

WASHINGTON

WAGGONER

THE

WASHINGTON

501 LAMAR BLVD.

CORRECTIONAL HOUSE

SECTION

COUNTY

PLACES

EVA

1934

WHITE

1934

HOME

1934

MARY ANN

MARY ANN

WASHINGTON

*Handwritten signature and notes*

1934

WASHINGTON

1934

1934

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10716

## CERTIFICATE OF DEATH

10704

Reg. Dist. No. 302

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>5 months</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALBERT</b> Middle <b>NELSON</b> Last <b>DEAL</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>27</b> Year <b>59</b>  |  |   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 20, 1902</b>                                    |  |
| 9. AGE (In years lost birthday)<br><b>57</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Roundhouse Foreman</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>John Deal</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Byrnes</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>705-10-5958</b>  |  | 17. INFORMANT<br><b>Mrs. Pauline Deal</b>  |  | Address<br><b>Hagerstown, Maryland</b>                                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Prostate</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Mo.</b><br><b>1 yr.</b> |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 18, 1958</b> , to <b>Sept 27th, 1959</b> , that I last saw the deceased alive on <b>9/27/59</b> , 19 <b>59</b> , and that death occurred at <b>2:45 AM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>J. G. Warden</i>   |  |  |  | M.D.   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>J. G. Warden, M. D.</b>   |  |  |  | <b>832 Potomac Ave., Hagerstown, Md.</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>9/30/1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>R. Franklin Brown</i>  |  |  |  | ADDRESS<br><b>Hagerstown, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 2 '59</b>                            |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Charles A. Kneass</i>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3095

10717

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>43 years</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maude</b> Middle Last <b>Deavers</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>19</b> Year <b>1959</b>   |  |  |   |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 24, 1894</b>                              |   |
| 9. AGE (In years last birthday)<br><b>64 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>kitchen work</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>hotel</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Brunswick, Md.</b>     |   |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Edward Rockwell</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Detrick</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>212-14-7590</b>   |  |  |   |
| 17. INFORMANT<br><b>Walter A. Deavers, Hagerstown, Md.</b>   |  |   |  | Address   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b><br>170X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) <b>Carcinoma of breast</b><br>(c) <b>(Paget's Disease of the Breast)</b> |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b><br><b>2 yr +</b>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
|  |  |   |  | 20f. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <b>Nov 15, 1954</b> to <b>Sept. 19, 1959</b> that I last saw the deceased alive on <b>Sept 19, 1959</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above.  |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE <b>L. L. Parker</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>145 W. Washington</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>L. L. Parker M.D.</b>   |  |   |  | DATE SIGNED <b>9/21/59</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  |   |  | 22b. DATE THEREOF<br><b>9-21-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>       |   |
|  |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md.</b>   |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 22 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kraus</b>                   |   |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10717

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF ENTRY: [illegible]

PLACE OF ENTRY: [illegible]

NAME OF REGISTRAR: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

DATE OF ENTRY: [illegible]

PLACE OF ENTRY: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

SIGNATURE OF REGISTRAR: [illegible]



10718

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |   |  |                                |  |  |
|---|----------------------------------|--|---|--|--------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> |                                |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |                                  |  |   | c. LENGTH OF STAY IN 1b<br><u>20 mos.</u>  |                                |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Western Maryland State Hospital</u>  |                                  |  |   | d. STREET ADDRESS<br><u>Apt. 38 Frederick St.</u>  |                                |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |  |                                |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Charles Paul Edmondson</u>   |                                  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Sept. 5 1959</u>  |                                |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 20, 1912</u> | 9. AGE (In years lost birthday)<br><u>46 yrs.</u>  | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>  |                                  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                                  |  |   |  |                                |  |  |
| 13. FATHER'S NAME<br><u>Charles Edmondson</u>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Fields</u>   |                                |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                                  |  |   | 16. SOCIAL SECURITY NO.<br><u>Mary Washington (sister) Ramo</u>  |                                |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u><br>020.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Neurosyphilis, congenital</u><br>DUE TO (c) _____ |                                  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>13 days</u><br><u>46 years</u>  |                                |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |  |   |  |                                |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19 _____   |                                  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
|   |                                  |  |   | 20f. (City or town) (County) (State)   |                                |  |  |
| 21. I certify that I attended the deceased from <u>Dec. 17</u> , 19 <u>57</u> , to <u>Sept. 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 5</u> , 19 <u>59</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.  |                                  |  |   |  |                                |  |  |
| ACTUAL SIGNATURE <u>Victor L. Ramos</u>   |                                  |  |   | M.D. <u>Western Maryland State Hosp. Sept. 5, 1959</u>   |                                |  |  |
| PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>  |                                  |  |   | <u>Hagerstown, Maryland</u>  |                                |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>9-8-59</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Burial Park</u>  |                                | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John F. ...</u>  |                                  |  |   | ADDRESS<br><u>Cumberland</u>   |                                | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 9 '59</u>                             |  |
|   |                                  |  |   |  |                                | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. ...</u>                           |  |

091

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BP

1870

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1870

*[Faint, illegible text and lines forming a form structure, likely containing fields for name, date, cause of death, etc.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10719

## CERTIFICATE OF DEATH

10707  
302

Reg. Dist. No.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>11 Hrs</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b><br>d. STREET ADDRESS<br><b>1032 So Colonial Drive</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>HARRY CAMERON ELGIN</b>   |                                     | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>19</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Nov 28 1892</b>   |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.  |                                     | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Peaverton Wash Co Md.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph Elgin</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Moore</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>314-09-9772</b>   |  |
| 17. INFORMANT<br><b>Cameron E. Elgin</b>   |                                     | Address<br><b>1032 So Colonial Dr Hagerstown Md</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b><br>DUE TO <b>241X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b><br>DUE TO <b>10 yrs</b><br>(c) <b>Chronic Asthma</b><br><b>10 yrs</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Nov 19 1959</b> , to <b>Sept 19 1959</b> , that I last saw the deceased alive on <b>Sept 19 1959</b> , and that death occurred at <b>6:10 P M</b> , from the causes and on the date stated above.   |                                     |   |  |
| ACTUAL SIGNATURE<br><b>Edwin J Hoachlen M.D.</b>   |                                     | DATE SIGNED<br><b>9/21/59</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Edwin J Hoachlen M.D.</b>  |                                     | <b>Hagerstown</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9/23/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash Co Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>   |                                     | ADDRESS<br><b>Hagerstown Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 '59</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>C. Coffman &amp; Thomas</b>  |  |

CERTIFICATE OF DEATH

1971

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY     |  | 2. SEX<br>M                                   |  | 3. AGE<br>35  |  |
| 4. DATE OF DEATH<br>APR 4 1968            |  | 5. TIME OF DEATH<br>10:00 AM                  |  | 6. PLACE OF DEATH<br>FEDERAL BUREAU OF INVESTIGATION    |  |
| 7. CAUSE OF DEATH<br>HEART DISEASE        |  | 8. MANNER OF DEATH<br>NATURAL                 |  | 9. PLACE OF BIRTH<br>MEMPHIS, TENN.                     |  |
| 10. OCCUPATION<br>ATTORNEY                |  | 11. EDUCATION<br>HIGH SCHOOL                  |  | 12. RELIGION<br>METHODIST                               |  |
| 13. MARITAL STATUS<br>MARRIED             |  | 14. DATE OF MARRIAGE<br>JAN 15 1965           |  | 15. NAME OF SPOUSE<br>JANE RAY                          |  |
| 16. NAME OF PHYSICIAN<br>DR. J. H. HARRIS |  | 17. NAME OF HOSPITAL<br>ST. JOSEPH'S HOSPITAL |  | 18. NAME OF FUNERAL HOME<br>JAMES EARL RAY FUNERAL HOME |  |
| 19. NAME OF MINISTER<br>REV. J. H. HARRIS |  | 20. NAME OF CHURCH<br>METHODIST CHURCH        |  | 21. NAME OF CEMETERY<br>GREENWOOD CEMETERY              |  |
| 22. NAME OF CORONER<br>JOHN J. HARRIS     |  | 23. NAME OF JURY<br>JAMES EARL RAY            |  | 24. NAME OF JURY<br>JANE RAY                            |  |
| 25. NAME OF JURY<br>JAMES EARL RAY        |  | 26. NAME OF JURY<br>JANE RAY                  |  | 27. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 28. NAME OF JURY<br>JANE RAY              |  | 29. NAME OF JURY<br>JAMES EARL RAY            |  | 30. NAME OF JURY<br>JANE RAY                            |  |
| 31. NAME OF JURY<br>JAMES EARL RAY        |  | 32. NAME OF JURY<br>JANE RAY                  |  | 33. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 34. NAME OF JURY<br>JANE RAY              |  | 35. NAME OF JURY<br>JAMES EARL RAY            |  | 36. NAME OF JURY<br>JANE RAY                            |  |
| 37. NAME OF JURY<br>JAMES EARL RAY        |  | 38. NAME OF JURY<br>JANE RAY                  |  | 39. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 40. NAME OF JURY<br>JANE RAY              |  | 41. NAME OF JURY<br>JAMES EARL RAY            |  | 42. NAME OF JURY<br>JANE RAY                            |  |
| 43. NAME OF JURY<br>JAMES EARL RAY        |  | 44. NAME OF JURY<br>JANE RAY                  |  | 45. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 46. NAME OF JURY<br>JANE RAY              |  | 47. NAME OF JURY<br>JAMES EARL RAY            |  | 48. NAME OF JURY<br>JANE RAY                            |  |
| 49. NAME OF JURY<br>JAMES EARL RAY        |  | 50. NAME OF JURY<br>JANE RAY                  |  | 51. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 52. NAME OF JURY<br>JANE RAY              |  | 53. NAME OF JURY<br>JAMES EARL RAY            |  | 54. NAME OF JURY<br>JANE RAY                            |  |
| 55. NAME OF JURY<br>JAMES EARL RAY        |  | 56. NAME OF JURY<br>JANE RAY                  |  | 57. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 58. NAME OF JURY<br>JANE RAY              |  | 59. NAME OF JURY<br>JAMES EARL RAY            |  | 60. NAME OF JURY<br>JANE RAY                            |  |
| 61. NAME OF JURY<br>JAMES EARL RAY        |  | 62. NAME OF JURY<br>JANE RAY                  |  | 63. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 64. NAME OF JURY<br>JANE RAY              |  | 65. NAME OF JURY<br>JAMES EARL RAY            |  | 66. NAME OF JURY<br>JANE RAY                            |  |
| 67. NAME OF JURY<br>JAMES EARL RAY        |  | 68. NAME OF JURY<br>JANE RAY                  |  | 69. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 70. NAME OF JURY<br>JANE RAY              |  | 71. NAME OF JURY<br>JAMES EARL RAY            |  | 72. NAME OF JURY<br>JANE RAY                            |  |
| 73. NAME OF JURY<br>JAMES EARL RAY        |  | 74. NAME OF JURY<br>JANE RAY                  |  | 75. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 76. NAME OF JURY<br>JANE RAY              |  | 77. NAME OF JURY<br>JAMES EARL RAY            |  | 78. NAME OF JURY<br>JANE RAY                            |  |
| 79. NAME OF JURY<br>JAMES EARL RAY        |  | 80. NAME OF JURY<br>JANE RAY                  |  | 81. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 82. NAME OF JURY<br>JANE RAY              |  | 83. NAME OF JURY<br>JAMES EARL RAY            |  | 84. NAME OF JURY<br>JANE RAY                            |  |
| 85. NAME OF JURY<br>JAMES EARL RAY        |  | 86. NAME OF JURY<br>JANE RAY                  |  | 87. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 88. NAME OF JURY<br>JANE RAY              |  | 89. NAME OF JURY<br>JAMES EARL RAY            |  | 90. NAME OF JURY<br>JANE RAY                            |  |
| 91. NAME OF JURY<br>JAMES EARL RAY        |  | 92. NAME OF JURY<br>JANE RAY                  |  | 93. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 94. NAME OF JURY<br>JANE RAY              |  | 95. NAME OF JURY<br>JAMES EARL RAY            |  | 96. NAME OF JURY<br>JANE RAY                            |  |
| 97. NAME OF JURY<br>JAMES EARL RAY        |  | 98. NAME OF JURY<br>JANE RAY                  |  | 99. NAME OF JURY<br>JAMES EARL RAY                      |  |
| 100. NAME OF JURY<br>JANE RAY             |  | 101. NAME OF JURY<br>JAMES EARL RAY           |  | 102. NAME OF JURY<br>JANE RAY                           |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

10708

10720

|  |                               |  |                                   |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>WASHINGTON</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>   |                               | c. LENGTH OF STAY IN 1b <b>50 YRS.</b>   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>JONAS</b> Last <b>FLOOK</b>   |                               | 4. DATE OF DEATH Month <b>SEPT.</b> Day <b>15</b> Year <b>19 59</b>  |                                   |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5/10/1886</b> |
| 9. AGE (In years lost birthday) <b>73</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   | 11. IF UNDER 24 HRS.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FIRE TRUCK DRIVER</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>CITY</b>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                   |
| 13. FATHER'S NAME <b>JONAS T. FLOOK</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>ANNA SHOEMAKER</b>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>  |                                   |
| 17. INFORMANT <b>MRS. CLARA S. FLOOK</b>   |                               | 18. ADDRESS <b>HAGERSTOWN MD.</b>  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the colon with intestinal obstruction</b> (b) <b>153.8</b> (c) <b>obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b> |                               |  |                                   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <b>Aug. 21</b> , 19 <b>59</b> to <b>Sept. 15</b> , 19 <b>59</b> that I last saw the deceased alive on <b>September 12, 1959</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>M.D. 148 West Washington St. Hagerstown, Maryland</b><br>DATE SIGNED <b>9/16/59</b>   |                               |  |                                   |
| ACTUAL SIGNATURE <b>B. B. Kneisley</b>   |                               | PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 22b. DATE THEREOF <b>9/18/59</b>   |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Korman</b>   |                               | ADDRESS <b>Hagerstown, Md.</b>   |                                   |
| 24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kneisley</b>   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10702

CERTIFICATE OF DEATH

10702

WASHINGTON STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

DECEASED'S NAME: \_\_\_\_\_

SEX: \_\_\_\_\_

AGE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

IMMEDIATE CAUSE: \_\_\_\_\_

UNDERLYING CAUSE: \_\_\_\_\_

INTERVIEWED BY: \_\_\_\_\_

DATE OF INTERVIEW: \_\_\_\_\_

SIGNATURE OF REGISTRAR: \_\_\_\_\_

DATE OF REGISTRATION: \_\_\_\_\_



## CERTIFICATE OF DEATH

10710

Reg. Dist. No.

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>             |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |                               | c. LENGTH OF STAY IN 1b <u>2 Weeks</u>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print) <u>DELLA M. FOWLER</u>   |                               | 4. DATE OF DEATH <u>SEPTEMBER 3</u> 19 <u>59</u>   |                                    |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-16-1882</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                    |
| 13. FATHER'S NAME <u>Joseph Tarnon</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u><br>194X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CARCINOMA of thyroid, METASTATIC LOCALLY.</u><br>DUE TO<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>9 Months</u>   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <u>JUNE 13</u> , 19 <u>59</u> , to <u>SEPT 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 3</u> , 19 <u>59</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.   |                               |  |                                    |
| ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> <u>9-3-59</u>   |                                    |
| PHYSICIAN'S NAME (Type) <u>EVARISTO R. LARDIZABAL HAGERSTOWN, Md</u>   |                               |  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>9-6-1959</u>  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Swittland Md</u>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u>  |                               | 24a. REC'D BY REGISTRAR <u>Wash DC</u> DATE <u>SEP 8 '59</u>   |                                    |
|  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>   |                                    |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10710

CERTIFICATE OF DEATH

10710

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10709

10722

Reg. Dist. No.

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>  |                               | c. LENGTH OF STAY IN 1b <b>Life</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>LEE</b> Last <b>FOX</b>  |                               | 4. DATE OF DEATH Month <b>Sept.</b> Day <b>15</b> Year <b>19 59</b>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 14, 1959</b> |
| 9. AGE (In years last birthday) yrs. <b>2</b>   |                               | 10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Howard L. Fox</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Audrey J. McManus</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>   |  |
| 17. INFORMANT <b>Mr. Howard L. Fox</b>  |                               | Address <b>130 N. Mulberry St. Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral anoxia and/or aspiration pneumonia</b><br>762.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Poor regulation of vital centers</b><br>DUE TO<br>(c) <b>Maternal cause; Ruptured uterus at 34 weeks</b> |                               |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 2</b>   |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Birth</b> , 19 <b>9-15</b> , to <b>death</b> , 19 <b>9-15</b> , that I last saw the deceased alive on <b>9-15</b> , 19 <b>59</b> , and that death occurred at <b>9:18 P.M.</b> , from the causes and on the date stated above.   |                               |  |  |
| ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.   |                               | DATE SIGNED <b>9/16/59</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b> M.D.  |                               | <b>318 N. Potomac St. Hagerstown, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>9/18/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>  |                               | ADDRESS <b>20813022 N. 3rd St. Hagerstown, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR <b>SEP 18 59</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur J. Thomas</b>   |  |

EVX20000

10723

Item 8 Film 3248 9-10-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN lb <b>13 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland Chronic Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Blue Ridge Summit Pa.</b><br>d. STREET ADDRESS <b>1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>EVALYN</b> First <b>LUCRETA</b> Middle <b>FRAZER</b> Last<br>4. DATE OF DEATH <b>SEPTEMBER 10</b> Month <b>19 59</b> Year   |  | 5. SEX <b>Female</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/><br>8. DATE OF BIRTH <b>7/22/1889</b><br>9. AGE (In years last birthday) <b>70</b> yrs.<br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b><br>11. BIRTHPLACE (State or foreign country) <b>Steubenville Ohio</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Henry Myers</b><br>14. MOTHER'S MAIDEN NAME <b>Margaret Brandt</b><br>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Dorothy McCleaf, Blue Ridge Summit Pa.</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>6000</b> DUE TO <b>Pyelonephritis</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>UNKNOWN</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHITIS HYPERTENSIVE CARDIO-VASCULAR DISEASE</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour o. m. <b>19</b> p. m.<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that I attended the deceased from <b>August 28</b> , 19 <b>59</b> , to <b>Sept 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 9</b> , 19 <b>59</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>1500 PENNSYLVANIA AVE</b> DATE SIGNED <b>9-10-59</b><br>ACTUAL SIGNATURE <b>Evaristo R. Lardizabal</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>EVARISTO R. LARDIZABAL HAGERSTOWN MD</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>22b. DATE THEREOF <b>9/13/59</b><br>22c. NAME OF CEMETERY OR CREMATORY <b>Broadfording</b><br>22d. LOCATION (City, town, or county) (State) <b>Hagerstown #5, Washington Md.</b>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Grove, Waynesboro Pa.</b> ADDRESS<br>24a. REC'D BY REGISTRAR <b>SEP 14 '59</b> DATE<br>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11701

CENTRAL BANK OF DEPOSIT

0733

11701

11701



## CERTIFICATE OF DEATH

Reg. Dist. No.

10724

|   |                                  |   |  |   |  |   |   |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2 weeks</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                            |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash. Co. Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>1 Interval Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nellie</b> Middle <b>Laura</b> Last <b>Harvey</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>24</b> Year <b>1959</b>   |  |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 26, 1912</b>  |  | 9. AGE (In years last birthday)<br><b>47</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>47</b> Days <b>47</b> Hours <b>47</b> Min. <b>47</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Thomas, W. Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Abe Harsh</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-30-8166</b>   |  | INFORMANT Address<br><b>Mrs. Betty Doub Hagerstown, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>174x Cancer of uterus</b><br>DUE TO (b) <b>6 m + t</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c)   |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 m + t</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized abd. metastases; pulm. emboli; thrombosed iliac veins</b>  |                                  |   |  |   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>14 Feb</b> , 19 <b>59</b> , to <b>24 Sept</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Sept</b> , 19 <b>59</b> , and that death occurred at <b>11:30 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>1135 POTOMAC AVENUE</b> DATE SIGNED <b>26 SEPT. 59</b> |                                  |   |  |   |  |   |   |
| ACTUAL SIGNATURE<br><b>Richard T. Binford</b>   |                                  | PHYSICIAN'S NAME (Type)<br><b>RICHARD T. BINFORD, M. D.</b>   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>9-28-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Fred W. Kraiss</b>   |                                  |   |  | ADDRESS<br><b>Hagerstown, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 29 '59</b>   |   |
|   |                                  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kraiss</b>   |   |

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

3570

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

10725

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |  |  |   |  |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington County</b>  |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Montgomery</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>               |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>4023 Jones Bridge Rd.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>HIPKINS, Joseph P.</b>   |                                  | Middle<br><b>P</b>  |  | Last<br><b>Hipkins</b>   |  | 4. DATE OF DEATH<br>Month<br><b>September</b> Day<br><b>19</b> Year<br><b>1959</b>                |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 27, 1897</b>  |  | 9. AGE (In years lost birthday) yrs.<br><b>62</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Electrician</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Electric</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Missouri</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Charles Hipkins</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Pearl Music</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Yes</b>   |  | 17. INFORMANT<br><b>Hospital record</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mesenteric vascular accident</b><br><b>153.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of descending colon</b><br>DUE TO<br>(c) _____ |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Left hemiplegia secondary to cerebral thrombosis; Pulmonary emphysema</b>   |                                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug. 15, 1959</b> to <b>Sept. 19, 1959</b> , that I last saw the deceased alive on <b>Sept. 18, 1959</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>170 W. Washington St., Hagerstown, Md.</b> |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Frank E. Brumback</b>  |                                  |   |  | PHYSICIAN'S NAME (Type)<br><b>Frank E. Brumback, M. D.</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>  |                                  | 22b. DATE THEREOF<br><b>9/22/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Geo. Wash. Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>                         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                  |   |  | ADDRESS<br><b>Bethesda, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 24 '59</b>  |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |  |   |  |



10726

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |   |   |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>41 YRS.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>918 SALEM AVE.</b>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RUTH</b> Middle <b>ALMIRA</b> Last <b>HOFFER</b>   |                                     | 4. DATE OF DEATH<br>Month <b>SEPT.</b> Day <b>28</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/25/1881</b>  |
| 9. AGE (In years lost birthday)<br><b>78</b>   |                                     | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>HANSON GRADY</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>SUSAN HOLDERMAN</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>214-09 7811</b>   |   |
| 17. INFORMANT<br><b>MRS. ELISE LUSBAUGH</b>  |                                     | 18. HAGERSTOWN MD.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Central Neutrosia</b><br><b>170X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ca. of Breast</b> DUE TO<br>(c) |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>5 yrs</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                                     | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>9-26</b> , 19 <b>59</b> , to <b>9-28</b> , 19 <b>59</b> that I last saw the deceased alive on <b>9-28</b> , 19 <b>59</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.  |                                     |   |   |
| ACTUAL SIGNATURE<br><b>John D. Turco</b>   |                                     | ADDRESS (Street, city or town, state)<br><b>302 N. POTOMAC ST Hagerstown Md.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>JOHN D. TURCO</b>  |                                     | DATE SIGNED<br><b>9-29-59</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>9/30/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROSEDALE CEM.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>MARTINSBURG W. VA.</b>                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Horment Hagerstown Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 5 1959</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur A. Thomas</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10701

CERTIFICATE OF DEATH

10701

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
BIRTH DATE  
BIRTH PLACE  
PARENTS  
SPOUSE  
CHILDREN  
BURIAL PLACE  
DATE OF BURIAL  
BY WHOM  
WITNESSES  
DECEASED'S SIGNATURE  
DECEASED'S ADDRESS  
DECEASED'S CITY  
DECEASED'S STATE  
DECEASED'S ZIP

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*



10727

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Md.</b>  |   | c. LENGTH OF STAY IN 1b<br><b>55yrs</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Maryland</b>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Robert W Hopewell</b>   |   | 4. DATE OF DEATH Month Day Year<br><b>Sept 19 19 59</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 11 1889</b>                                    |
| 9. AGE (In years—lost birthday) yrs.<br><b>70</b>   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>70</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Junk yard</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Louis Hopewell</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknew</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>yes World War I</b>   |   | 16. SOCIAL SECURITY NO.<br><b>214-09-9526</b>   |   |
| 17. INFORMANT<br><b>Mrs Dorthy Gurlin</b>   |   | Address<br><b>47 W. Bethel St.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>                         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>July 20</b> , 19 <b>59</b> , to <b>Sept. 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 19</b> , 19 <b>59</b> , and that death occurred at <b>5:27P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>DSt 100 Professional Arts Bldg.</b> DATE SIGNED <b>9/21/59</b>  |   |   |   |
| ACTUAL SIGNATURE<br><i>William T. Layman</i>  |   | M.D. <b>100 Professional Arts Bldg.</b>   |   |
| PHYSICIAN'S NAME (Type) <b>William T. Layman</b>  |   | <b>Hagerstown Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9-22-1959</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>John R Watson Jr</i>   |   | ADDRESS<br><b>Hagerstown Md</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>SEP 25 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur E. Hume</i>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1250

10728

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Maryland</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>55yrs.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>125 Blooms Alley</b>  |  |   |  | d. STREET ADDRESS<br><b>125 Blooms Alley</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Virgie</b> Middle <b>Mae</b> Last <b>Johnson</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>23</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 25 1882</b>  |  |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Loudon County, Va.</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Lucas Hiram</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Beem</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>William Johnson</b> Address <b>125 Blooms Alley</b>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b><br><b>153.8</b> DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>6-12 mo.</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>Sept 1, 1959</b> to <b>Sept 23, 1959</b> , that I last saw the deceased alive on <b>Sept 1, 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b> DATE SIGNED <b>9/23/59</b>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D.  |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b> <b>159 W. Washington St., Hagerstown, Md.</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>9-26-1959</b>     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John R. Watson Jr.</b>  |  |   |  | ADDRESS<br><b>Hagerstown Md</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 29 '59</b>   |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur R. Thomas</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729

## CERTIFICATE OF DEATH

Reg. Dist. No.

10717

302

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>33 Yrs</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>24 Winter St</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>KATHERINE ELIZABETH KENDLE</b>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>September 29 1959</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov 29 1879</b>   |  |
| 9. AGE (In years last birthday) yrs.<br><b>79</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Wash Co Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Thadeous Munday</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Rosana Bloomenour</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT Address<br><b>Lester G Kendle 353 Devonshire Rd</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Semibilty &amp; myocardial insufficiency</b><br>DUE TO <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Arteriosclerosis</b> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>Years</b>                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus</b>  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>28 Sept 1959</b> to <b>29 Sept 1959</b> , that I last saw the deceased alive on <b>28 Sept 1959</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown Wash Co Md.</b><br>DATE SIGNED <b>9/29/59</b>   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J. W. Wilson</b>   |  | M.D. <b>9/29/59</b>  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10/1/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash Co Md.</b>         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>   |  |  |  | ADDRESS<br><b>Hagerstown Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 2 '59</b>                                       |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur A. Frank</b>   |  |  |  |



CERTIFICATE OF DEATH

|                                   |  |                             |  |                           |  |
|-----------------------------------|--|-----------------------------|--|---------------------------|--|
| 1. Name of deceased               |  | 2. Sex                      |  | 3. Age                    |  |
| 4. Date of death                  |  | 5. Time of death            |  | 6. Place of death         |  |
| 7. Cause of death                 |  | 8. Manner of death          |  | 9. Signature of physician |  |
| 10. Signature of registrar        |  | 11. Signature of informant  |  | 12. Signature of witness  |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker |  | 15. Signature of cemetery |  |
| 16. Signature of health officer   |  | 17. Signature of coroner    |  | 18. Signature of jury     |  |
| 19. Signature of jury             |  | 20. Signature of jury       |  | 21. Signature of jury     |  |
| 22. Signature of jury             |  | 23. Signature of jury       |  | 24. Signature of jury     |  |
| 25. Signature of jury             |  | 26. Signature of jury       |  | 27. Signature of jury     |  |
| 28. Signature of jury             |  | 29. Signature of jury       |  | 30. Signature of jury     |  |
| 31. Signature of jury             |  | 32. Signature of jury       |  | 33. Signature of jury     |  |
| 34. Signature of jury             |  | 35. Signature of jury       |  | 36. Signature of jury     |  |
| 37. Signature of jury             |  | 38. Signature of jury       |  | 39. Signature of jury     |  |
| 40. Signature of jury             |  | 41. Signature of jury       |  | 42. Signature of jury     |  |
| 43. Signature of jury             |  | 44. Signature of jury       |  | 45. Signature of jury     |  |
| 46. Signature of jury             |  | 47. Signature of jury       |  | 48. Signature of jury     |  |
| 49. Signature of jury             |  | 50. Signature of jury       |  | 51. Signature of jury     |  |
| 52. Signature of jury             |  | 53. Signature of jury       |  | 54. Signature of jury     |  |
| 55. Signature of jury             |  | 56. Signature of jury       |  | 57. Signature of jury     |  |
| 58. Signature of jury             |  | 59. Signature of jury       |  | 60. Signature of jury     |  |
| 61. Signature of jury             |  | 62. Signature of jury       |  | 63. Signature of jury     |  |
| 64. Signature of jury             |  | 65. Signature of jury       |  | 66. Signature of jury     |  |
| 67. Signature of jury             |  | 68. Signature of jury       |  | 69. Signature of jury     |  |
| 70. Signature of jury             |  | 71. Signature of jury       |  | 72. Signature of jury     |  |
| 73. Signature of jury             |  | 74. Signature of jury       |  | 75. Signature of jury     |  |
| 76. Signature of jury             |  | 77. Signature of jury       |  | 78. Signature of jury     |  |
| 79. Signature of jury             |  | 80. Signature of jury       |  | 81. Signature of jury     |  |
| 82. Signature of jury             |  | 83. Signature of jury       |  | 84. Signature of jury     |  |
| 85. Signature of jury             |  | 86. Signature of jury       |  | 87. Signature of jury     |  |
| 88. Signature of jury             |  | 89. Signature of jury       |  | 90. Signature of jury     |  |
| 91. Signature of jury             |  | 92. Signature of jury       |  | 93. Signature of jury     |  |
| 94. Signature of jury             |  | 95. Signature of jury       |  | 96. Signature of jury     |  |
| 97. Signature of jury             |  | 98. Signature of jury       |  | 99. Signature of jury     |  |
| 100. Signature of jury            |  | 101. Signature of jury      |  | 102. Signature of jury    |  |



THE STATE OF TEXAS, DEPARTMENT OF HEALTH, BAYLOR  
COUNTY OF \_\_\_\_\_, TEXAS  
I, \_\_\_\_\_, Registrar of the County of \_\_\_\_\_, State of Texas, do hereby certify that the foregoing is a true and correct copy of the original record of the death of \_\_\_\_\_, as the same appears in the records of the Department of Health, State of Texas, at the City of \_\_\_\_\_, State of Texas, on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10718

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>W. Va.</b> b. COUNTY <b>Morgan</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hancock</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Paw Paw</b> 85x-3  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Hancock Convalescent Home</b>  |                                  | d. STREET ADDRESS   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Deneen</b> Last <b>Kifer</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>9,</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br><b>June 23, 1895</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Month <b>2</b> Day <b>16</b>   | IF UNDER 24 HRS.<br>Hours <b>16</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bldg. Contractor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kifer, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>David Kifer</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Ashkettle</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Catharine Kifer, Kifer Maryland.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arterio Sclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell in bath tub</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>Dec 1959</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b> |  |
| 20f. (City or town)<br><b>Paw Paw</b>   |                                  | (County)<br><b>W. Va</b> (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .                  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Dr. SW Dittus</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>Dr. E W Dittus</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  | DATE SIGNED<br><b>9/9/59</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9/13/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rosa Hill Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles J. Inge</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>SEP 14 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur G. Kiser</b>  |                                  |   |  |

10718

# NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                               |  |                    |  |
|-------------------------------|--|--------------------|--|
| Name of Deceased              |  | John Joseph Miller |  |
| Sex                           |  | Male               |  |
| Race                          |  | White              |  |
| Date of Birth                 |  | March 15, 1885     |  |
| Place of Birth                |  | New York           |  |
| Usual Residence               |  | New York           |  |
| Cause of Death                |  | Heart Disease      |  |
| Manner of Death               |  | Natural            |  |
| Signature of Medical Examiner |  | [Signature]        |  |
| Date of Death                 |  | March 15, 1918     |  |
| Place of Death                |  | New York           |  |
| Signature of Coroner          |  | [Signature]        |  |
| Date of Certificate           |  | March 15, 1918     |  |
| Place of Certificate          |  | New York           |  |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10766

## CERTIFICATE OF DEATH

10719

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BOONSBORO</u>   |                               | c. LENGTH OF STAY IN 1b<br><u>64 YEARS</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>REEDER NURSING HOME</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>FLORENCE VIRGINIA KLINE</u>   |                               | 4. DATE OF DEATH <u>SEPT. 6 - 1959</u>   |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 25, 1880</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>NR. MYERSVILLE FRED. CO. MD. U.S.A.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>JACOB SHANK</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>ELLA ALEXANDER</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   |
| 17. INFORMANT <u>ALTON B. KLINE</u>  |                               | Address <u>BOONSBORO MD. R. 2</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u><br>450.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> |                               |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>July 20, 1957</u> to <u>Sept. 6, 1959</u> , that I last saw the deceased alive on <u>Sept. 4, 1959</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>9/8/59</u>   |   |
| PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>   |                               | <u>Ind</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>SEPT. 8, 1959</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Coats</u> ADDRESS <u>BOONSBORO MD.</u>   |                               | 24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>   |   |
|  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10720

10730

Reg. Dist. No. 302

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b><br>d. STREET ADDRESS <b>114 E. Franklin Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>MATTIE First LAVINIA Middle KROUSE Last</b>  |                               | 4. DATE OF DEATH <b>September 17 19 59</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>January 30, 1914</b> |
| 9. AGE (In years last birthday) <b>45 yrs.</b>  |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Ribbon Factory</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>John W. Snyder</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Estella Gearhart</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                               | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Edwin W. Krouse</b>  |                               | Address <b>Hagerstown, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>916.0 Third Degree Burns of 90% of Body</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)   |                               | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>lighting cigarette &amp; caught fire from electric stove</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>12 NOV 9/16 19 59</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>  |                               | 20f. (City or town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |  |
| ACTUAL SIGNATURE <b>Howard N. Weeks</b>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>9/19/1959</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>   |                               | ADDRESS <b>Hagerstown, Maryland</b>  |  |
| 24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>  |  |

MEDICAL CERTIFICATION

081

1

0

21

2



FOR STATE  
HEALTH DEPT.

Washington Army Hospital

1 day

Washington Army Hospital

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                               |  |                                       |  |  |
|---|-------------------------------|--|---------------------------------------|--|--|
| Item 18 Film 249 10-5-59 ams  |                               | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |                                       | 10721  |  |
| 10731   |                               |  |                                       |  |  |
| CERTIFICATE OF DEATH  |                               |  |                                       |  |  |
| Reg. Dist. No.  |                               |  |                                       |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>Washington</b>         |                                       |  |  |
| c. LENGTH OF STAY IN 1b <b>28 days</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>   |                                       |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland Hospital</b>   |                               | d. STREET ADDRESS <b>225 W. Antietam Street</b>  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Norman</b> Middle <b>Harry</b> Last <b>Lapole</b>   |                               | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>29</b> Year <b>1959</b>   |                                       |  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>April 28 1937</b> | 9. AGE (In years last birthday) <b>22</b> yrs.   | IF UNDER 1 YEAR <b>5</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |                                       | 11. BIRTHPLACE (State or foreign country) <b>Chestnut Grove Md.</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>   |                               |  |                                       |  |  |
| 13. FATHER'S NAME <b>Wilbur John Lapole</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Ellen Iola Gross</b>   |                                       |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                       | INFORMANT <b>Mr. Wilbur Lapole</b> Address <b>225 W. Antietam St. Sharpsburg Maryland</b>      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br><b>1939</b> DUE TO <b>sarcomatosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arterio-sclerosis</b><br>DUE TO <b>Neurofibrosarcoma of humerus</b><br>(c) <b>8 hours</b><br><b>5 years</b><br><b>8 years</b> |                               |  |                                       |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                               |  |                                       |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |                               |  |                                       |  |  |
| 21. I certify that I attended the deceased from <b>Aug. 31</b> , 1959, to <b>Sept. 29</b> , 1959, that I last saw the deceased alive on <b>Sept. 29</b> , 1959, and that death occurred at <b>2:15 P.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Western Md. State Hospital</b> DATE SIGNED <b>Sept. 29/59</b>   |                               |  |                                       |  |  |
| ACTUAL SIGNATURE <b>Victor L. Ramos</b>   |                               | M.D. <b>Western Md. State Hospital</b>   |                                       |  |  |
| PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS</b>  |                               | <b>Hagerstown, Maryland</b>  |                                       |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Oct. 3 1959</b>   |                                       | 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>                                    |  |
| 22d. LOCATION (City, town, or county) <b>Sharpsburg Md.</b>   |                               | (State)  |                                       |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. Williams</b>  |                               | ADDRESS <b>Sharpsburg, Md</b>  |                                       | 24a. REC'D BY REGISTRAR <b>DATE OCT 2 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>   |                               |  |                                       |  |  |

STATE OF TEXAS  
COUNTY OF DALLAS

10031

John A. Smith

25 days

John A. Smith

John A. Smith

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John A. Smith

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10722

Reg. Dist. No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  | c. LENGTH OF STAY IN 1b<br><b>15 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Myersville 10X-2</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington Co. Hospital</b>   |  | d. STREET ADDRESS<br><b>Route # 2 Wolfsville</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>JACKSON</b> Last <b>LEATHERMAN</b>   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>5</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 25, 1893</b>   |
| 9. AGE (in years last birthday)<br><b>66</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b>  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cabinet maker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Morgans Lumber Mill</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Jacob Harlan Leatherman</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Frushour</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>215-36-6968</b>   |  |
| 17. INFORMANT<br><b>Mrs. Rae Leatherman, Myersville, Md</b>  |  | Address <b>Rt. # 2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>910.3</b> <b>Ischemic Corporation of Germany</b><br>DUE TO <b>fatal poisoning</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO <b></b><br>(c) <b></b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Struck in stomach by board from rip saw</b>              |  |
| 20c. TIME OF INJURY<br>Hour <b>3:30</b> a.m. <b>p.m.</b><br>Month, Day, Year <b>8-21 1959</b>  | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>factory</b>  | 20f. (City or town) <b>Wolfsville</b> (County) <b>Fred. Co.</b> (State) <b>Md.</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |
| ACTUAL SIGNATURE<br><b>F. W. Dittler</b>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>F. W. Dittler</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Sept. 8, 1959</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mark's Luth.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Wolfsville, Fred. Co. Md.</b>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul R. Bittle</b>  |  | ADDRESS<br><b>Myersville, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>SEP 8 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Huns</b>   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10723

10733

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>15 years</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>103 W. Franklin Street</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>EDWIN</b> Last <b>LEWIS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>12</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 26, 1891</b>   |
| 9. AGE (In years last birthday)<br><b>67 yrs.</b>  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired janitor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Drug Store</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William H. Lewis</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Clara A. Wolf</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>214-09-4699</b>   |   |
| 17. INFORMANT<br><b>George W. Lewis</b>  |                                  | Address<br><b>Hagerstown, Maryland</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1 Pulmonary Edema</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b><br>DUE TO (c) <b>Arteriosclerotic Cardiac Vascular Disease</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 weeks</b><br><b>several years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>8/31/59</b> 19____, to <b>9/12/59</b> 19____, that I last saw the deceased alive on <b>9/8/59</b> 19____, and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE<br><b>Howard N. Weeks, M.D.</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>136 North Potomac St. 9/14/59</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Howard N. Weeks, M.D.</b>  |                                  | <b>Hagerstown, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>9/14/1959</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Rouzer Funeral Home</b>   |                                  | ADDRESS<br><b>Hagerstown, Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE<br><b>SEP 15 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>  |   |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10734

CERTIFICATE OF DEATH

Reg. Dist. No.

10724

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 days</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sadah</b> Middle <b>Raye</b> Last <b>Long</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>3</b> Year <b>19 59</b>   |  |  |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 10, 1895</b>                               |   |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |   |
| 13. FATHER'S NAME<br><b>J. Hooker Lewis</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura V. Kelbaugh</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>180-22-3963 A</b>   |  |  |   |
| 17. INFORMANT<br><b>Roy A. Long</b>   |  |   |  | Address<br><b>Thurmont, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>237x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) <b>Pulmonary embolism</b><br>DUE TO<br>(c) <b>During subocc. craniotomy for brain tumor</b> |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>few minutes</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)  |  |   |  | 20g. (City or town) (County) (State)  |  |  |   |
| 21. I certify that I attended the deceased from <b>8/31</b> , 19 <b>59</b> , to <b>9/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/3</b> , 19 <b>59</b> , and that death occurred at <b>12:30</b> P. M. from the causes and on the date stated above.   |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE <b>A. F. Abdullah</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>132 W. Potomac</b>   |  |  |   |
| PHYSICIAN'S NAME (Type) <b>A. F. Abdullah</b>   |  |   |  | DATE SIGNED <b>9/3/59</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 22b. DATE THEREOF<br><b>9-6-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Creagerstown Cem.</b>         |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Creagerstown, Maryland</b>  |  |   |  | 22e. LOCATION (City, town, or county) (State)   |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b>   |  |   |  | ADDRESS<br><b>Thurmont, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 8 '59</b>                            |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |  |   |  | 24c. REGISTRAR'S SIGNATURE  |  |  |   |

10324

CERTIFICATE OF DEATH

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 Maryland  
 Frederick

Washington County Hospital

180-22-3965 A  
 No. 1  
 J. Hooker Lewis  
 Own Home  
 Maryland  
 U.S.A.  
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Raymond S. Greager  
 Thimont, Md.  
 Greagerstown Com.  
 Hagerstown, Maryland

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

CERTIFICATE OF DEATH

10725

Reg. Dist. No.

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland Hospital</b>   |                               | d. STREET ADDRESS <b>652 W. Washington St.</b>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |
| 3. NAME OF DECEASED (Type or print) <b>CLARENCE SYLVESTER McBRIDE</b> First Middle Last   |                               | 4. DATE OF DEATH <b>September 18</b> Month Day Year <b>1959</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. 16 1900</b>          |
| 9. AGE (In years lost birthday) <b>58</b> yrs.  |                               | IF UNDER 1 YEAR <b>11</b> Months <b>1</b> Days   | IF UNDER 24 HRS. <b>1</b> Hours <b>1</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer at Pangborn</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Manf. of Dust Collectors</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Ronney W. Va.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   |
| 13. FATHER'S NAME <b>William Newton Mc Bride</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Elsie Kidwell</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>232-26-6152</b>   |   |
| 17. INFORMANT <b>Mrs. Wilbur Carbaugh</b>   |                               | Address <b>Maugansville Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA AND CONGESTION</b><br>163X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CONFLUENT LOBULAR PNEUMONIA</b><br>DUE TO<br>(c) <b>CARCINOMA RIGHT LUNG, REGIONAL METASTASIS</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>5 days</b><br><b>3 YEARS</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CORONARY ATHEROSCLEROSIS, SEVERE</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>August 10</b> , 19 <b>59</b> , to <b>Sept. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>59</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <b>Evaristo R. Lardizabal</b> M.D.   |                               | ADDRESS (Street, city or town, state) <b>1500 PENNSYLVANIA AVE</b>   |   |
| PHYSICIAN'S NAME (Type) <b>EVARISTO R. LARDIZABAL Hagerstown, Md.</b>   |                               | DATE SIGNED <b>9-18-59</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Sept. 22-59</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Blairs' Valley, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Wilkerson</b>  |                               | ADDRESS <b>Blairs' Valley, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR <b>SEP 22 '59</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>   |   |

10735

10735

CENTRIFUGAL DEATH

WESTERN STATE DEPARTMENT OF HEALTH - BUREAU OF

Health - 10735

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

10736

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>14 years</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2316 Jefferson Blvd.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b><br>d. STREET ADDRESS <b>2316 Jefferson Blvd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>P.</b> Middle <b>WALTER</b> Last <b>MC CLAIN</b>   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>24</b> Year <b>1959</b>   |   |
| 5. SEX <b>male</b>   | 6. COLOR OR RACE <b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>July 9, 1895</b>                                      |
| 9. AGE (In years last birthday) <b>64</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Guard</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Edgemont, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>Walter M. Mc Clain</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Nettie G. Dowler</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO. <b>214-09-1893</b>  |   |
| 17. INFORMANT <b>Mrs. Margaret V. Mc Clain</b>   |  | Address <b>Hagerstown, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b><br><b>162.1</b> DUE TO <b>Bronchogenic Carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>18 mos.</b><br>DUE TO (c) |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I attended the deceased from <b>Jan. 58</b> to <b>Sept. 24 59</b> , that I last saw the deceased alive on <b>Sept. 27 1959</b> and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>9-25-59</b>               |  |   |   |
| ACTUAL SIGNATURE <b>D. J. Boyer</b>  |  | PHYSICIAN'S NAME (Type) <b>D. J. Boyer</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>9/26/1959</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg, Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>  |  | 24a. REC'D BY REGISTRAR <b>SEP 26 1959</b>  |   |
| ADDRESS <b>Hagerstown, Md.</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Edward A. Pinner</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Coroner's papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10727

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10737

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>  |  | c. LENGTH OF STAY IN 1b<br><u>7 mo.</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown Md.</u>                                     |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Prospect Street</u>   |  |   |   | d. STREET ADDRESS<br><u>Prospect Street</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Joe</u> Middle <u>Marie</u> Last <u>Mc Pherson</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>9</u> Year <u>1959</u>  |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan. 26 1959</u>     |   | 9. AGE (In years last birthday)<br><u>7</u> yrs. | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>13</u>   | IF UNDER 24 HRS.<br>Hours <u>13</u> Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A</u>  |   |
| 13. FATHER'S NAME<br><u>Robert Mc Pherson</u>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Trixie Berneda Stevens</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT<br><u>Mrs. Raymond Staley</u> <u>Pinesburg Williamsport Md RFD</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>922.0</u> DUE TO <u>Suffocation by foreign body</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>in mouth &amp; throat</u><br>DUE TO (c) <u>5 minutes</u>  |  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Baby put rattle in mouth</u>                             |   |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>8</u> <u>9-8-59</u> <u>p. m.</u>  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   | 20f. (City or town)<br><u>Hagerstown Md</u> | (County)  | (State)  |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |   |   |  |   |   |
| ACTUAL SIGNATURE<br><u>A. J. W. Smith</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED<br><u>9/9/59</u>  |  |   |   |
| EXAMINER'S NAME (Type)<br><u>FREWITT</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Sept. 11-59</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Greenlawn Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport Maryland</u>   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Alfred Britton</u>  |  |   |   | ADDRESS<br><u>WILLIAMSPORT MD</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 10 '59</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur &amp; Thara</u>   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2081244XV6



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10728

Reg. Dist. No.

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>                         |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |  | c. LENGTH OF STAY IN 1b<br><u>71 yrs.</u>            |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u> |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Route 3</u>   |  |  |  | d. STREET ADDRESS<br><u>Route 3</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>George</u> Middle <u>Nelson</u> Last <u>Messner</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>20</u> Year <u>19 59</u>  |   |   |  |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>March 27, 1888</u>   |  |  |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |   |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>W.M.R.R.</u> |   | 11. BIRTHPLACE (State or foreign country)<br><u>Thurmont, Md.</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |
| 13. FATHER'S NAME<br><u>George W. Messner</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Rodgers</u>  |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212-14-7304A</u>   |  | 17. INFORMANT<br><u>Jesse E. Messner</u>  |   | Address<br><u>Hagerstown, Md.</u>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion ( Rt. )</u><br>825X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO (c) <u>Fracture 4th. &amp; 5th. Ribs Rt.</u><br>22 hours<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.<br><u>Auto accident</u>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Auto accident</u> |  |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>7</u> p. m. <u>9-19-19 59</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>S. Potomac St. Ext. Hagerstown</u>   |   | 20f. (City or town) (County) (State)<br><u>Washington Md.</u>   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |  |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |  |
| EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |  | 22b. DATE THEREOF<br><u>9-23-59</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Zion Brethren</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Luray Va.</u>                                     |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Fred W. Kraiss</u>  |  |  |  | ADDRESS<br><u>Hagerstown, Md.</u>   |   | 24a. REC'D BY-REGISTRAR<br><u>SEP 25 '59</u><br>DATE  |  |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>C. E. Kraiss</u>   |   | DATE SIGNED<br><u>9-21-59</u>   |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |                               |  |
|---|--|-------------------------------|--|
| 1. DECEASED'S NAME<br>Last, first, middle initial |  | 2. SEX<br>Male Female         |  |
| 3. DATE OF BIRTH                                  |  | 4. PLACE OF BIRTH             |  |
| 5. DATE OF DEATH                                  |  | 6. PLACE OF DEATH             |  |
| 7. TIME OF DEATH                                  |  | 8. CAUSE OF DEATH             |  |
| 9. MANNER OF DEATH                                |  | 10. SIGNATURE OF EXAMINER     |  |
| 11. SIGNATURE OF WITNESS                          |  | 12. SIGNATURE OF CORONER      |  |
| 13. SIGNATURE OF JURY                             |  | 14. SIGNATURE OF JUDGE        |  |
| 15. SIGNATURE OF CLERK                            |  | 16. SIGNATURE OF NOTARY       |  |
| 17. SIGNATURE OF CHURCH                           |  | 18. SIGNATURE OF FUNERAL HOME |  |
| 19. SIGNATURE OF BURIAL                           |  | 20. SIGNATURE OF CREMATION    |  |
| 21. SIGNATURE OF INTERMENT                        |  | 22. SIGNATURE OF REINTERMENT  |  |
| 23. SIGNATURE OF REINTERMENT                      |  | 24. SIGNATURE OF REINTERMENT  |  |
| 25. SIGNATURE OF REINTERMENT                      |  | 26. SIGNATURE OF REINTERMENT  |  |
| 27. SIGNATURE OF REINTERMENT                      |  | 28. SIGNATURE OF REINTERMENT  |  |
| 29. SIGNATURE OF REINTERMENT                      |  | 30. SIGNATURE OF REINTERMENT  |  |
| 31. SIGNATURE OF REINTERMENT                      |  | 32. SIGNATURE OF REINTERMENT  |  |
| 33. SIGNATURE OF REINTERMENT                      |  | 34. SIGNATURE OF REINTERMENT  |  |
| 35. SIGNATURE OF REINTERMENT                      |  | 36. SIGNATURE OF REINTERMENT  |  |
| 37. SIGNATURE OF REINTERMENT                      |  | 38. SIGNATURE OF REINTERMENT  |  |
| 39. SIGNATURE OF REINTERMENT                      |  | 40. SIGNATURE OF REINTERMENT  |  |
| 41. SIGNATURE OF REINTERMENT                      |  | 42. SIGNATURE OF REINTERMENT  |  |
| 43. SIGNATURE OF REINTERMENT                      |  | 44. SIGNATURE OF REINTERMENT  |  |
| 45. SIGNATURE OF REINTERMENT                      |  | 46. SIGNATURE OF REINTERMENT  |  |
| 47. SIGNATURE OF REINTERMENT                      |  | 48. SIGNATURE OF REINTERMENT  |  |
| 49. SIGNATURE OF REINTERMENT                      |  | 50. SIGNATURE OF REINTERMENT  |  |
| 51. SIGNATURE OF REINTERMENT                      |  | 52. SIGNATURE OF REINTERMENT  |  |
| 53. SIGNATURE OF REINTERMENT                      |  | 54. SIGNATURE OF REINTERMENT  |  |
| 55. SIGNATURE OF REINTERMENT                      |  | 56. SIGNATURE OF REINTERMENT  |  |
| 57. SIGNATURE OF REINTERMENT                      |  | 58. SIGNATURE OF REINTERMENT  |  |
| 59. SIGNATURE OF REINTERMENT                      |  | 60. SIGNATURE OF REINTERMENT  |  |
| 61. SIGNATURE OF REINTERMENT                      |  | 62. SIGNATURE OF REINTERMENT  |  |
| 63. SIGNATURE OF REINTERMENT                      |  | 64. SIGNATURE OF REINTERMENT  |  |
| 65. SIGNATURE OF REINTERMENT                      |  | 66. SIGNATURE OF REINTERMENT  |  |
| 67. SIGNATURE OF REINTERMENT                      |  | 68. SIGNATURE OF REINTERMENT  |  |
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| 79. SIGNATURE OF REINTERMENT                      |  | 80. SIGNATURE OF REINTERMENT  |  |
| 81. SIGNATURE OF REINTERMENT                      |  | 82. SIGNATURE OF REINTERMENT  |  |
| 83. SIGNATURE OF REINTERMENT                      |  | 84. SIGNATURE OF REINTERMENT  |  |
| 85. SIGNATURE OF REINTERMENT                      |  | 86. SIGNATURE OF REINTERMENT  |  |
| 87. SIGNATURE OF REINTERMENT                      |  | 88. SIGNATURE OF REINTERMENT  |  |
| 89. SIGNATURE OF REINTERMENT                      |  | 90. SIGNATURE OF REINTERMENT  |  |
| 91. SIGNATURE OF REINTERMENT                      |  | 92. SIGNATURE OF REINTERMENT  |  |
| 93. SIGNATURE OF REINTERMENT                      |  | 94. SIGNATURE OF REINTERMENT  |  |
| 95. SIGNATURE OF REINTERMENT                      |  | 96. SIGNATURE OF REINTERMENT  |  |
| 97. SIGNATURE OF REINTERMENT                      |  | 98. SIGNATURE OF REINTERMENT  |  |
| 99. SIGNATURE OF REINTERMENT                      |  | 100. SIGNATURE OF REINTERMENT |  |

*[Handwritten signature]*

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10768**  
**CERTIFICATE OF DEATH**

**10729**

Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FAIRPLAY - RURAL</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>LIFE</u> |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FAIRPLAY - RURAL</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>FAIRPLAY MD. 12.1</u>  |  |  |  | d. STREET ADDRESS<br><u>FAIRPLAY MD. R. 1</u>   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE W. MIDDLEKAUF</u>   |  |  |  | 4. DATE OF DEATH <u>SEPT-14-1959</u>  |  |   |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MAY-15-1881</u>                     |  | 9. AGE (In years last birthday) <u>78</u> yrs.  |  |
|   |  | 8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>3</u> Days <u>29</u> Hours <u></u> Min. <u></u>           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN FARM</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>FAIRPLAY WASH. CO. MD. U.S.A.</u>                           |  |
| 13. FATHER'S NAME<br><u>AARON C. MIDDLEKAUF</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>LAURA EAKLE</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>219-36-2503</u>   |  | 17. INFORMANT<br><u>MRS. ALBERT V. FORD FAIRPLAY MD. 13.1</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Heart failure</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Chronic Myocardial insufficiency</u> DUE TO<br>(c) <u></u> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>5 yrs</u>  |  |
|   |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |  |  |  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |  |
|   |  |  |  | 20f. (City or town)   |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>9-10</u> , 19 <u>59</u> , to <u>9-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>59</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Max E. Byrkit</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>28 W. Potomac St</u> DATE SIGNED <u>9-15-59</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Max E. Byrkit, M.D.</u>  |  |  |  | <u>Williamsport, Md</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>SEPT. 17 1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>BAKERSVILLE CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>BAKERSVILLE WASH. CO. MD.</u>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Best</u> ADDRESS <u>BOONSBORO MD.</u>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 21 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Frank</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DO MAX BYRKIT  
28 W. POTOMAC ST  
X WILLIAMSPORT





1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to understand the preferences and behaviors of potential customers. Once a need is identified, the next step is to develop a concept that addresses this need. This concept should be unique, valuable, and feasible. The third step is to create a prototype of the product. This allows the team to test the concept and make necessary adjustments. The fourth step is to conduct a pilot test, where the product is introduced to a small group of customers to gather feedback. Finally, the product is launched into the market, and the team monitors its performance and makes further improvements as needed.



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10738  
CERTIFICATE OF DEATH

10730

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>14 YEARS, 03</u> <u>HAGERSTOWN</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>249 MILL STREET, 'HAGER PARK'</u>  |  |  |  | 1d. STREET ADDRESS <u>249 MILL ST. 'HAGER PARK'</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>BESSIE AMELIA MILLER</u>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>SEPTEMBER 19 1959</u>  |  |  |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>MARCH 28 1886</u>  |  |
| 9. AGE (In years last birthday) <u>73</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> |  | 11. BIRTHPLACE (State or foreign country) <u>TILGHMANTON WASH. CO. MD. U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>SAMUEL B. HARTLE</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ELLEN SHOWE</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |  |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u><br>443X DUE TO <u>Hypertensive C. S. Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Diabetes Mellitus</u><br>DUE TO (c) <u>5th</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)   |  |  |  | 21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> to <u>9/19/59</u> , that I last saw the deceased alive on <u>6/19/59</u> , 19 <u>59</u> and that death occurred at <u>6:00</u> M, from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <u>SEARL YOUNG</u> M.D. <u>145 M. Potomac</u>   |  |  |  | ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>SEARL YOUNG M.D.</u>  |  |  |  | DATE SIGNED <u>SEP 22 1959</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>SEPT 22 1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>NR. TILGHMANTON WASH. CO. MD.</u>             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Best</u> ADDRESS <u>BOONSBORO MD</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>  |  |

DR. S. EARL YOUNG  
145 N. POTOMAC ST.  
M



## CERTIFICATE OF DEATH

Reg. Dist. No.

10739

10731

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b <b>8 yrs.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARCUS</b> Middle <b>ROBINSON</b> Last <b>MILLER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>11</b> Year <b>19 59</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 16, 1920</b>  |
| 9. AGE (In years last birthday) <b>39</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min. <b>39</b>  | 11. IF UNDER 24 HRS.<br>Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min. <b>39</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Chester Martin Miller</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Lula Taylor</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <b>214-05-4525</b>   |  |
| 17. INFORMANT <b>Mrs. M.R. Miller</b>  |                                  | Address <b>328 N. Mulberry St. Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis</b><br><b>416X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. (b) <b>Rheumatic Heart Disease.</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>None.</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b><br><b>Years.</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>August 30, 19 59</b> , to <b>Sept. 11, 19 59</b> , that I last saw the deceased alive on <b>Sept. 10, 19 59</b> , and that death occurred at <b>6:15 A.</b> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <b>R.A. Bell</b>  |                                  | ADDRESS (Street, city or town, state) <b>119 N. Potomac Street, 9-12-59</b>  |  |
| PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>   |                                  | Hagerstown, Maryland.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>9/14/59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |                                  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR <b>SEP 15 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>  |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10732

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

|                  |  |                |  |                |  |                |  |                |  |                 |  |                        |  |                        |  |                             |  |                             |  |                             |  |
|------------------|--|----------------|--|----------------|--|----------------|--|----------------|--|-----------------|--|------------------------|--|------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|
| Name of Deceased |  | Sex            |  | Age            |  | Date of Birth  |  | Place of Birth |  | Usual Residence |  | Cause of Death         |  | Place of Death         |  | Time of Death               |  | Signature of Physician      |  | Signature of Registrar      |  |
| John D. Smith    |  | Male           |  | 45             |  | Jan 15, 1920   |  | West Virginia  |  | West Virginia   |  | Heart Disease          |  | Home                   |  | 10:30 PM                    |  | [Signature]                 |  | [Signature]                 |  |
| Occupation       |  | Marital Status |  | Education      |  | Religion       |  | Color          |  | Last Illness    |  | Duration of Illness    |  | Attending Physician    |  | Burial Place                |  | Burial Date                 |  | Burial Time                 |  |
| Teacher          |  | Married        |  | High School    |  | Methodist      |  | White          |  | Pneumonia       |  | 2 Weeks                |  | Dr. J. H. Jones        |  | Cemetery                    |  | Jan 20, 1965                |  | 11:00 AM                    |  |
| Date of Death    |  | Time of Death  |  | Place of Death |  | Cause of Death |  | Place of Death |  | Time of Death   |  | Signature of Physician |  | Signature of Registrar |  | Signature of Burial Officer |  | Signature of Burial Officer |  | Signature of Burial Officer |  |
| Jan 18, 1965     |  | 10:30 PM       |  | Home           |  | Heart Disease  |  | Home           |  | 10:30 PM        |  | [Signature]            |  | [Signature]            |  | [Signature]                 |  | [Signature]                 |  | [Signature]                 |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

10740

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural RD#6</b> 10X-2                                       |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |   | d. STREET ADDRESS<br><b>Bartonsville</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Gerald E.</b> Middle <b>Moberly</b> Last <b>Moberly</b>  |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>11</b> Year <b>1959</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 10, 1909</b>                                   |
| 9. AGE (In years last birthday) yrs.<br><b>50</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Same</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George H. B. Moberly</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Viola Roelke</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>214-10-5271</b>   |   |
| 17. INFORMANT<br><b>Mrs. Helen M. Moberly- Same as Item #2</b>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Circulatory failure</b><br>DUE TO (b) <b>Massive infarct (RT) Cerebral hemisphere 2 days.</b><br>DUE TO (c) <b>Atherosclerosis and cerebral thrombosis</b><br>CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause last. |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>9/9</b> , 19 <b>59</b> , to <b>9/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/11</b> , 19 <b>59</b> , and that death occurred at <b>3:15 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>132 N. Potomac</b><br>DATE SIGNED  |   |   |   |
| ACTUAL SIGNATURE <b>A-F. Abdullah</b> M.D.   |   | ADDRESS <b>132 N. Potomac</b>   |   |
| PHYSICIAN'S NAME (Type) <b>A-F. Abdullah</b>   |   | ADDRESS <b>Hagerstown, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Sept. 14, 1959</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 15 '59</b>   |   |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur B. Kline</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10741

CERTIFICATE OF DEATH

Reg. Dist. No. 11909

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>  |                                  | c. LENGTH OF STAY IN 1b <u>15 MINUTES</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>BERTHA AILEEN MULLENDORF</u>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPTEMBER 29 1959</u>   |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>APRIL 20 - 1893</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><u>J. CALVIN FLOOK</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>OLIVE BOWMAN</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> If yes, give war or dates of service  |                                  | 16. SOCIAL SECURITY NO. <u>217-12-1414</u>   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u><br>200.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>MALIGNANT LYMPHOMA</u> DUE TO<br>(c) <u>30 Days.</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>August 18-29-1959</u> to <u>September 29 1959</u> , that I lost sight of the deceased on <u>10 A.M.</u> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>Joseph J. Seconari</u>  |                                  | ADDRESS (Street, city or town, state) <u>BOONSBORO MARYLAND</u>  |  |
| PHYSICIAN'S NAME (Type) <u>SECONARI JOSEPH</u>  |                                  | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                                  | 22b. DATE THEREOF <u>OCT 2 1959</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>  |                                  | 22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bad</u>   |                                  | ADDRESS <u>BOONSBORO MD</u>  |  |
| 24a. REC'D BY REGISTRAR   |                                  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>  |  |

081

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10721

1

SECONDARY JOSEPH  
18-44-21  
August 27 1944  
BONSBORO HAYWARD  
BONSBORO HAYWARD  
BONSBORO HAYWARD

## CERTIFICATE OF DEATH

Reg. Dist. No.

10742

|  |                               |   |                                       |   |   |  |  |
|--|-------------------------------|---|---------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>   |                               |   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>   |                               |   |                                       | c. LENGTH OF STAY IN 1b <u>10 DAYS</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. HOSPITAL</u>   |                               |   |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | d. STREET ADDRESS <u>ST. PAUL ST.</u>                                  |  |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>D</u> Last <u>MULLOOLY</u>   |                               |   |                                       | 4. DATE OF DEATH Month <u>SEPTEMBER</u> , Day <u>22</u> , Year <u>1959</u>  |   |  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL-19-1908</u> | 9. AGE (In years lost birthday) <u>51</u> yrs.  | IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PACKAGE LIQUOR STORE OPERATOR-OWN STORE</u>   |                               |   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>MT. SAVAGE</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |
| 13. FATHER'S NAME <u>ARTHUR MULLOOLY</u>   |                               |   |                                       | 14. MOTHER'S MAIDEN NAME <u>CATHERINE GRAY</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.2.</u>   |                               |   |                                       | 16. SOCIAL SECURITY NO. <u>214-07-1931</u>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u><br>581.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>LIVER CIRRHOSIS</u><br>DUE TO (c) <u></u> |                               |   |                                       | INTERVAL BETWEEN ONSET AND DEATH <u>10 Days.</u>  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                               |   |                                       | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                               |   |                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |                               |   |                                       |   |   |  |  |
| 21. I certify that I attended the deceased from <u>9-12-</u> , 19 <u>59</u> , to <u>9-23-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-21-</u> , 19 <u>59</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.   |                               |   |                                       |   |   |  |  |
| ACTUAL SIGNATURE <u>Joseph Secondari</u>   |                               |   |                                       | ADDRESS (Street, city or town, state) <u>Boonsboro MD</u>   |   |  |  |
| PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI MD</u>   |                               |   |                                       | DATE SIGNED <u>9-23-59</u>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               |   |                                       | 22b. DATE THEREOF <u>SEPT. 26. 1959</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>CREST LAWN CEMETERY</u>          |  |
| 22d. LOCATION (City, town, or county) (State) <u>LAVALLE ALLEGHENY CO. MD.</u>   |                               |   |                                       |   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Boat</u>   |                               |   |                                       | ADDRESS <u>Boonsboro MD.</u>  |   | 24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>                         |  |
|  |                               |   |                                       |   |   | 24b. REGISTRAR'S SIGNATURE <u>Charles A. Kline</u>                     |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

ABDUL KADIR

QADIR

QADIR

QADIR

1

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

10743

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2 months 18d.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELIZABETH</b> Middle <b>SUSAN</b> Last <b>PALMER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>17</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 8, 1901</b> |
| 9. AGE (In years last birthday)<br><b>57</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>near Downsville, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Edward Dorsey</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Danner</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   |
| 17. INFORMANT<br><b>W. Herman Palmer</b>  |                                  | Address<br><b>Hagerstown, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary infarction &amp; pneumonia</b><br>DUE TO <b>450.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Marked generalized atherosclerosis</b><br>DUE TO <b>3-4 yrs</b><br>(c)    |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 wks.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hypertension, Cardiac failure, Liver congestion</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>30 JUNE</b> , 19 <b>59</b> , to <b>17 SEPT.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>16 SEPTEMBER</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>135 POTOMAC AVENUE</b> <b>18 SEPT. 1959</b> |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Richard T. Binford</b>   |                                  | PHYSICIAN'S NAME (Type)<br><b>RICHARD T. BINFORD, M. D.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9/19/1959</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>River View Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Franklin Royer</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>SEP 21 '59</b>  |   |
| ADDRESS<br><b>Hagerstown, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Gilbert &amp; K...</b>   |   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                 |  |                  |  |
|---------------------------------|--|------------------|--|
| NAME OF DECEASED                |  | WASHINGTON       |  |
| SEX                             |  | MALE             |  |
| AGE                             |  | 21               |  |
| DATE OF BIRTH                   |  | JANUARY 1, 1900  |  |
| PLACE OF BIRTH                  |  | WASHINGTON, D.C. |  |
| OCCUPATION                      |  | STUDENT          |  |
| CAUSE OF DEATH                  |  | TUBERCULOSIS     |  |
| DATE OF DEATH                   |  | JANUARY 15, 1921 |  |
| PLACE OF DEATH                  |  | WASHINGTON, D.C. |  |
| SIGNATURE OF PHYSICIAN          |  | J. H. HARRIS     |  |
| SIGNATURE OF REGISTRAR          |  | J. H. HARRIS     |  |
| SIGNATURE OF WITNESSES          |  | J. H. HARRIS     |  |
| SIGNATURE OF DECEASED           |  | J. H. HARRIS     |  |
| SIGNATURE OF FUNERAL HOME       |  | J. H. HARRIS     |  |
| SIGNATURE OF BURIAL PLACE       |  | J. H. HARRIS     |  |
| SIGNATURE OF INTERVIEWER        |  | J. H. HARRIS     |  |
| SIGNATURE OF REPORTER           |  | J. H. HARRIS     |  |
| SIGNATURE OF CLERK              |  | J. H. HARRIS     |  |
| SIGNATURE OF CHIEF CLERK        |  | J. H. HARRIS     |  |
| SIGNATURE OF ASSISTANT CLERK    |  | J. H. HARRIS     |  |
| SIGNATURE OF DEPUTY CLERK       |  | J. H. HARRIS     |  |
| SIGNATURE OF RECORDS CLERK      |  | J. H. HARRIS     |  |
| SIGNATURE OF INDEXER            |  | J. H. HARRIS     |  |
| SIGNATURE OF FILE CLERK         |  | J. H. HARRIS     |  |
| SIGNATURE OF DISTRIBUTION CLERK |  | J. H. HARRIS     |  |
| SIGNATURE OF ARCHIVIST          |  | J. H. HARRIS     |  |
| SIGNATURE OF LIBRARIAN          |  | J. H. HARRIS     |  |
| SIGNATURE OF CURATOR            |  | J. H. HARRIS     |  |
| SIGNATURE OF SUPERVISOR         |  | J. H. HARRIS     |  |
| SIGNATURE OF MANAGER            |  | J. H. HARRIS     |  |
| SIGNATURE OF DIRECTOR           |  | J. H. HARRIS     |  |



10744

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   | c. LENGTH OF STAY IN 1b<br><b>46 years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>344 West Side Ave.</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lillian</b> Middle <b>Virginia</b> Last <b>Pittenger</b>  |   | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>16</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 26, 1890</b>                                |
| 9. AGE (In years last birthday)<br><b>69 yrs.</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Franklin Co. Pa.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Pa.</b>  |  |
| 13. FATHER'S NAME<br><b>Daniel M. Whetstone</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucy Irwin</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>-----</b>  |   | 16. SOCIAL SECURITY NO.<br><b>-----</b>   |  |
| INFORMANT<br><b>Mrs W. Lyman Ott</b>  |   | Address<br><b>Hagerstown Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Metastasis</b><br><b>200.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Lympho Sarcoma</b><br>DUE TO<br>(c) <b>-----</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b><br><b>7 mos.</b>     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>-----</b> p. m. <b>-----</b> 19 <b>59</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>  | 20f. (City or town) (County) (State)<br><b>-----</b>                   |
| 21. I certify that I attended the deceased from <b>Apr. 15, 1959</b> to <b>16 Sept 59</b> , that I last saw the deceased alive on <b>15 Sept 59</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><b>J. D. Wilson</b>   |   | ADDRESS (Street, city or town, state)<br><b>135 N. Potomac St. Hagerstown Md.</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>J. D. Wilson</b>  |   | DATE SIGNED<br><b>9/16/59</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9-18-59</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son</b>   |   | ADDRESS<br><b>Hagerstown Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>SEP 21 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10132

CERTIFICATE OF DEATH

10132

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Washington

Washington

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344 West 10th Ave.

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10745

## CERTIFICATE OF DEATH

Reg. Dist. No.

10736

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|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  | c. LENGTH OF STAY IN 1b<br><b>6 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <b>Ann</b> First <b>Straight</b> Middle <b>Poe</b> Last  |  | 4. DATE OF DEATH <b>September 27 1959</b> Month <b>September</b> Day <b>27</b> Year <b>1959</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 3, 1902</b>  |
| 9. AGE (In years last birthday)<br><b>57</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>5</b> Hours <b>1</b> Min.  | 11. IF UNDER 24 HRS.<br>Months <b>4</b> Days <b>5</b> Hours <b>1</b> Min.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Grags Falls, W.Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Arizona</b>  |   |
| 13. FATHER'S NAME<br><b>Willie S. Straight</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Arizona Haught</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   |
| 17. INFORMANT<br><b>G. Edward Poe</b>  |  | Address<br><b>Hagerstown Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>170X Hepatic Coma</b><br>DUE TO (b) <b>metabolic Ca</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <b>Cerebral left vent</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>4-5 months</b><br><b>2 y 6 m</b>           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>7/1/59</b> , 19 <b>59</b> , to <b>9/27/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/28/59</b> , 19 <b>59</b> , and that death occurred at <b>12:45 AM</b> from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D.   |  | ADDRESS (Street, city or town, state) <b>136 N. Potomac St</b> DATE SIGNED <b>9/28/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Howard N. Weeks</b>   |  | <b>Hagerstown, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9-30-59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Luthern Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Leitersburg Md.</b>                           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son</b>  |  | ADDRESS<br><b>Hagerstown Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>OCT 1 59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hume</b>   |   |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10708

DEPARTMENT OF HEALTH AND HUMAN SERVICES

10708

5

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

27

September

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September

AND

27

1902

Public Works

Public Security

Public

Public

Public

Public

Public

Public

Public

18:55

1902

Howard N. Weeks

Eastern Cemetery

1902

Public

Public

10746

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |                                  |  |  |   |   |   |                  |
|--|----------------------------------|--|--|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>5 Yrs</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                                      |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>72 East Ave</b>   |                                  |  |  | d. STREET ADDRESS<br><b>72 East Ave</b>   |   |   |                  |
| 3. NAME OF DECEASED<br>(Type or print) <b>LeROY NMN POLSGROVE</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>8</b> Year <b>1959</b>  |   |   |                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Oct 15 1886</b> | 9. AGE (In years last birthday)<br><b>72</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b> |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pa. St Thomas Franklin Co</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                  |
| 13. FATHER'S NAME<br><b>Jesse H. Polsgrove</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary C Graham</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>W.W.# 1 314-09-7633</b>  |  | 17. INFORMANT<br><b>Mrs Daisy M. Polsgrove 72 East Ave</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Large Bowel.</b><br><b>153.8</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>(c)<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Colostomy performed November 1958.</b> |                                  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 months</b>  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <b>Nov. 4, 1958</b> , to <b>Sept. 8, 1959</b> , that I last saw the deceased alive on <b>Sept. 8, 1959</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.   |                                  |  |  |   |   |   |                  |
| ACTUAL SIGNATURE <b>R.A. Bell</b>  |                                  |  |  | ADDRESS (Street, city or town, state) <b>119 North Potomac St., 9-9-59</b>  |   |   |                  |
| PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>   |                                  |  |  | DATE SIGNED <b>Hagerstown, Maryland.</b>  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>9/11/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash Co Md</b>                     |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md</b>   |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 14 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kneass</b>   |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove colored papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

Reg. Dist. No.

10738

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>54 years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>31 Randolph Ave.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Lydia</b> First <b>Miner</b> Middle <b>Rudisill</b> Last  |                                  | 4. DATE OF DEATH<br><b>Sept. 1</b> Month <b>1</b> Day <b>59</b> Year  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 7, 1882</b>     |
| 9. AGE (In years birth day) <b>76</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>6</b> Hours <b>15</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>15</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Smithsburg, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>John Miner</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Bowman</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |
| 17. INFORMANT<br><b>George A. Rudisill, Hagerstown, Md.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO<br><b>Arterio sclerosis</b> (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b><br><b>1 yr.</b><br><b>yr.</b> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug 29, 1959</b> to <b>Sept. 1, 1959</b> , that I last saw the deceased alive on <b>Sept. 1, 1959</b> , and that death occurred at <b>3:10 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>9/2/59</b>   |                                  |   |  |
| ACTUAL SIGNATURE <b>Clayd A. Hoffman</b> M.D.   |                                  | PHYSICIAN'S NAME (Type) <b>Clayd A. Hoffman</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>9-3-59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 4 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |                                  |   |  |

10789

10787

Washington

Washington

30 Maryland Ave.

1918

Female white

Honolulu

John Baker

Honolulu

George A. Honolulu, Honolulu, HI.

1

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10739

Reg. Dist. No.

10748

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>23 years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>518 W. Howard St</b>   |                                  |   | d. STREET ADDRESS<br><b>518 W. Howard St.</b>   |  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Carrie Summer Seibert</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>28</b> Year <b>19 59</b>  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 28, 1873</b>  |  | 9. AGE (In years last birthday)<br><b>85</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Shady Grove Pa.</b>                                      |   |
| 13. FATHER'S NAME<br><b>Elias Summer</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elmira Fouke</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT Address<br><b>J. Clarke Seibert, Hagerstown, Md.</b>                                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X</b><br>DUE TO (b) <b>Hypertensive Cardio-Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Wisen</b>   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |   |
|   |                                  |   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |
| ACTUAL SIGNATURE<br><b>A. E. W. Ditt</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED<br><b>9/29/59</b>  |   |
| EXAMINER'S NAME (Type)<br><b>A. E. W. DITT</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-1-59</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Ref. Church</b>                                      |   |
|   |                                  |   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Western Pike, Hag., Md.</b>                          |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>  |                                  |   | 24a. REC'D BY REGISTRAR<br><b>OCT 5 7 59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur A. Hager</b>  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

10242

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Washington

Age 20 years

23 years

Hagerstown

510 N. Howard St.

510 N. Howard St.

Female

White

Married Nov. 28, 1923

Home

Own home

510 N. Howard St.

Single

Single

None

J. Charles Gelpert, Hagerstown, Md.

10-1-23

10-1-23

10-1-23

Dr. E. Linnick & Co., Hagerstown, Md.

Dr. E. Linnick & Co., Hagerstown, Md.

Dr. E. Linnick & Co., Hagerstown, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10740

Reg. Dist. No.

10769

|  |  |                                  |                                 |   |  |   |   |   |  |  |  |   |  |
|--|--|----------------------------------|---------------------------------|---|--|---|---|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>  |  |                                  |                                 | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓          |  |   |   |   |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Hagerstown</u>  |  |                                  | c. LENGTH OF STAY IN 1b<br><br> |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Waynesboro</u> <u>75 x 3</u> |   |   |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>R.D.5 Hagerstown</u>  |  |                                  |                                 | d. STREET ADDRESS<br><u>R.D.3 Waynesboro</u>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Samuel</u> Middle <u>Lester</u> Last <u>Shank</u>   |  |                                  |                                 | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>5</u> Year <u>19 59</u>  |  |   |   |   |  |  |  |   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u> |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Feb. 25, 1896</u>  |   | 9. AGE (In years last birthday)<br><u>63</u> yrs.                         |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  |  | IF UNDER 24 HRS.<br>Hours Min.                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>carpenter</u>  |  |                                  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Construction</u>  |  |   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Waynesboro, Pa. R.D.3</u> |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |
| 13. FATHER'S NAME<br><u>Simon Shank</u>  |  |                                  |                                 |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sadie Benchoff</u>   |   |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  |                                  |                                 | 16. SOCIAL SECURITY NO.<br><u>173-03-1285</u>   |  |   |   | 17. INFORMANT<br><u>Fred L. Shank Smithsburg, Md. R.D.2</u>               |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:<br/>           IMMEDIATE CAUSE (a) <u>823X</u> DUE TO<br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture Skull</u><br/>           DUE TO (c) <u>instant</u> </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH<br/> <u>1</u> </div> </div> |  |                                  |                                 |   |  |   |   |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                  |                                 |   |  |   |   |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  |                                  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Auto failed to make turn highway hitting pole</u>        |  |   |   |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year <u>9-5-59</u><br>Hour <u>8</u> a.m. <u>9</u> p.m.  |  |                                  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><u>Marsh Lake</u>                                |   | 20f. (City or town)<br><u>Hagerstown Wash. Md.</u>                        |  | (County)<br><br>   |  | (State)<br><br>                               |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |                                  |                                 |   |  |   |   |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>A. W. Sutter</u>   |  |                                  |                                 | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   | DATE SIGNED <u>9/6/59</u>   |  |  |  |   |  |
| EXAMINER'S NAME (Type)<br><u>D. E. W. D. T. T. T.</u>  |  |                                  |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>               |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                                  |                                 | 22b. DATE THEREOF<br><u>9/8/1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Green Hill</u>   |   |   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Waynesboro, Penna.</u> |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter J. Kane</u>  |  |                                  |                                 |   |  | ADDRESS<br><u>Waynesboro, Pa.</u>   |   | 24a. REC'D BY REGISTRAR<br><u>DATE SEP 9 '59</u>                          |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kane</u>                        |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

## CERTIFICATE OF DEATH

Reg. Dist. No. 10741

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 weeks</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown Md.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |                                  | d. STREET ADDRESS<br><b>413 Ross St.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Silas</b> Middle <b>Thomas</b> Last <b>Shank</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>12</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 10 1888</b> |
| 9. AGE (In years lost birthday)<br><b>71</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>1</b> Days <b>1</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret'd Foreman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Silk Mill</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Luray Va.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>   |   |
| 13. FATHER'S NAME<br><b>Thomas Shank</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annabelle Bateman</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>165 10 9851</b>  |   |
| 17. INFORMANT<br><b>Mrs. Helen Shank</b>   |                                  | Address<br><b>413 Ross St. Hagerstown Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Apoplexy</b><br><b>334x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b></b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>9/11/59</b> , 19 <b>59</b> , to <b>9/12/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/11/59</b> , 19 <b>59</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.                               |                                  | ADDRESS (Street, city or town, state) DATE SIGNED <b>9/14/59</b>   |   |
| ACTUAL SIGNATURE <b>Robert F. Young M.D.</b>   |                                  | PHYSICIAN'S NAME (Type) <b>William Spott, M.D.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Sept. 16-59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Edna Britton Williamsport Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 15 '59</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Krasa</b>   |                                  |  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10750

## CERTIFICATE OF DEATH

Reg. Dist. No.

10742

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>FAYMAN</b> Last <b>SHILLING Sr.</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>9</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 10, 1905</b> |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>54</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sheetmetal Supvr.</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pangborn Corp. (Mfg)</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Chewsville, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph H. Shilling</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Grey</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-09-5961</b>   |  |
| 17. INFORMANT<br><b>Mrs. J. F. Shilling</b>   |                                  | Address<br><b>604 Summit Ave. Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>757.1</b> DUE TO <b>Bilateral polycystic kidneys, and</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>uremia</b> DUE TO (c) <b>congenital</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk.</b>   |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>multiple cysts of liver and pancreas</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Oct 21</b> , 19 <b>58</b> , to <b>Sept 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 9</b> , 19 <b>59</b> , and that death occurred at <b>1:55 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>115 King St. Hagerstown, Md.</b> DATE SIGNED <b>Joseph C. Crisp M.D.</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9/12/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 14 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |                                  |   |  |

10750

CERTIFICATE OF DEATH

10750

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| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |                               |  |  |  |  |  |   |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|---|--|--|--|
| Item 20 Film 249 10-5-59 ams  |  |                               |  |  |  |  |  |   |  |  |  |
| 10751   |  |                               |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |                               |  |  |  |  |  |   |  |  |  |
| Reg. Dist. No. 10743  |  |                               |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b><br>c. LENGTH OF STAY IN 1b   |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAPLEVILLE</b> |  |   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>  |  |                               |  |  |  | d. STREET ADDRESS <b>MAIN ST.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last <b>CHARLES A. SHOOP</b>  |  |                               |  |  |  | 4. DATE OF DEATH<br>Month Day Year <b>SEPTEMBER - 18. 1959</b>   |  |   |  |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>JUNE 26 - 1870</b>   |  | 9. AGE (In years last birthday) <b>89</b> yrs.                                    |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BLACK SMITH - OWN SHOP</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>MAPLEVILLE WASH. CO. MD. U.S.A.</b>   |  |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |                               |  |  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME <b>JONATHAN SHOOP</b>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <b>LYDIA MYERS</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                               |  |  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |   |  |  |  |
| 17. INFORMANT <b>MRS. ELMER REEDER</b>  |  |                               |  |  |  | Address <b>MAPLEVILLE MD.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b><br>904.7 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture of right hip</b><br>DUE TO (c) |  |                               |  |  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  |  |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                               |  |  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Undressing to go to bed, lost balance &amp; fell</b>     |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>8 Hour <b>9-11-59</b><br>p. m.  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Conv. Home</b>   |  | 20f. (City or town) (County) (State)<br><b>Hagerstown Wash Md.</b>                |  |  |  |
| 21. I certify that I attended the deceased from <b>Sept 12</b> , 19 <b>59</b> , to <b>Sept 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>59</b> , and that death occurred at <b>11 P.</b> M, from the causes and on the date stated above.   |  |                               |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>G. W. Wilkerson</b>   |  |                               |  | ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b>   |  |  |  | DATE SIGNED <b>9/21/59</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>G. W. Wilkerson</b>  |  |                               |  |  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                               |  | 22b. DATE THEREOF <b>SEPT. 21-1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>FAHRNEYS CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>NR. MAPLEVILLE WASH. CO. MD.</b> |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Badt</b>  |  |                               |  | ADDRESS <b>Boonsboro MD.</b>   |  | 24a. REC'D BY REGISTRAR <b>SEP 25 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kraus</b>                              |  |  |  |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10770 CERTIFICATE OF DEATH

Reg. Dist. No.

10744

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEWSVILLE RURAL</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>34 YEARS</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HAGERSTOWN MD. R.F.D.</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RUTH</b> Middle <b>E</b> Last <b>SHOOP</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>12</b> Year <b>1959</b>  |  |  |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>JANUARY 2 - 1895</b>                                 |  |
| 9. AGE (In years lost birthday) <b>64</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min.                                |  | 11. BIRTHPLACE (State or foreign country) <b>MAPLEVILLE WASH. CO. MD. U.S.A.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |  |  |  |
| 13. FATHER'S NAME <b>JONAS MOSER</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>MINNIE WEAVER</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>220-34-6780</b>   |  |  |  |
| 17. INFORMANT <b>EDGAR R. SHOOP</b>   |  |   |  | Address <b>CHEWSVILLE MD.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>leucocy (leucoblastic) thrombocytopenia</b><br>260X DUE TO <b>leucoblastic thrombocytopenia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>leucoblastic thrombocytopenia</b><br>DUE TO <b>leucoblastic thrombocytopenia</b><br>(c) <b>leucoblastic thrombocytopenia</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 mts</b><br><b>10 yrs</b><br><b>10 yrs</b><br><b>11 yrs</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>Sept 10, 1959</b> to <b>Sept 19, 1959</b> , that I last saw the deceased alive on <b>Sept 19, 1959</b> , and that death occurred on <b>Sept 19, 1959</b> at <b>10:30 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Smithsburg Md</b> DATE SIGNED <b>9/19/59</b>   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>G. G. K. Ober</b>   |  |   |  | M.D. <b>Smithsburg Md</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>G. G. K. OHLER</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 22b. DATE THEREOF <b>SEPT. 23, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Baer</b>  |  |   |  | ADDRESS <b>BOONSBORO MD.</b>   |  | 24a. REC'D BY REGISTRAR <b>SEP 25 '59</b>                                |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE <b>Carroll A. Frank</b>   |  |  |  |

DR. KOHLER

10701

CENTRE OF DEATH

10701

10701

10701

10701



# CERTIFICATE OF DEATH

10745

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55



## CERTIFICATE OF DEATH

Reg. Dist. No.

10771

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NR. CLEAR SPRING</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING, MD.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRVIEW ROAD RESIDENCE</b>   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY MARTHA SHUPP</b>  |  | 4. DATE OF DEATH Month Day Year <b>SEPT. 25 1959</b>   |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>APRIL 25, 1890</b>                                   |
| 9. AGE (In years last birthday) <b>69</b> yrs.  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>5</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME DUTIES</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>FOUR LOCKS, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>SAMUEL H. FERNSNER</b>   |  | 14. MOTHER'S MAIDEN NAME <b>MARY ELIZA BREWER</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |
| 17. INFORMANT <b>ALVEY J. SHUPP</b>   |  | Address <b>ROUTE 1, CLEAR SPRING, MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 Coronary artery occlusion with myocardial infarction</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>unknown</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <b>Sept. 25, 1959</b> , to <b>September 25, 1959</b> , that I last saw the deceased <b>before he died Sept. 25, 1959</b> , and that death occurred at <b>9:40 P. M.</b> from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.  |  | ADDRESS (Street, city or town, state) DATE SIGNED  |  |
| PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>  |  | <b>Clear Spring, Maryland September 27, 1959</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 22b. DATE THEREOF <b>SEPT. 28, 1959</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEM.</b>   | 22d. LOCATION (City, town, or county) (State) <b>WASHINGTON MARYLAND</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i> ADDRESS <b>Clear Spring, Md.</b>  |  | 24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>   | 24b. REGISTRAR'S SIGNATURE <i>Arthur H. Harris</i>                       |

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1071

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

STATE OF MARYLAND, COUNTY OF BALTIMORE, I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 12th day of May, 1912, at Baltimore, Maryland, died \_\_\_\_\_

\_\_\_\_\_ of \_\_\_\_\_

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## CERTIFICATE OF DEATH

Reg. Dist. No.

10753

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|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>                                      |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Clifford Wade Simmons</b>   |                                  |   |  | 4. DATE OF DEATH Month Day Year<br><b>September 24 19 59</b>  |   |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1909 November 23,</b> | 9. AGE (In years last birthday) yrs.<br><b>49</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck driver</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Swope Augusta Co. Va.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |  |
| 13. FATHER'S NAME<br><b>Harry A. Simmons</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Whisman</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>324-07-9313</b>   |  | 17. INFORMANT<br><b>Mrs. Margie Simmons</b>   |   |   | Address<br><b>222 South Prospect St.</b> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial Infarction</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>atelectasis of right lower lobe due to chronic infection</b><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>retrobulbar endocarditis</b><br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I attended the deceased from <b>9-19</b> 19 <b>59</b> , to <b>9-24</b> 19 <b>59</b> , that I last saw the deceased alive on <b>9-24</b> 19 <b>59</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <b>John D. Turco</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>JOHN D. TURCO</b> <b>302 W. POTOMAC ST HAGERSTOWN MD</b><br>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>9-28 -59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Churchville Augusta Co. Va.</b><br>23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Andrew K. Coffman Hagerstown Md.</b> 24a. REC'D BY REGISTRAR <b>OCT 2 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b> |                                  |   |  |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br><i>John D. Smith</i>            |  | 2. SEX<br><i>Male</i>                                    |  |
| 3. AGE<br><i>65</i>                                    |  | 4. RACE<br><i>White</i>                                  |  |
| 5. DATE OF DEATH<br><i>Jan 15 1925</i>                 |  | 6. TIME OF DEATH<br><i>10:30 AM</i>                      |  |
| 7. PLACE OF DEATH<br><i>Home</i>                       |  | 8. CAUSE OF DEATH<br><i>Heart Disease</i>                |  |
| 9. DISEASE OR INJURY<br><i>Coronary Artery Disease</i> |  | 10. MEDICAL HISTORY<br><i>None</i>                       |  |
| 11. SIGNATURE OF PHYSICIAN<br><i>John D. Smith</i>     |  | 12. SIGNATURE OF WITNESSES<br><i>John D. Smith</i>       |  |
| 13. SIGNATURE OF DECEASED<br><i>John D. Smith</i>      |  | 14. SIGNATURE OF BURIAL OFFICIAL<br><i>John D. Smith</i> |  |
| 15. SIGNATURE OF REGISTRAR<br><i>John D. Smith</i>     |  | 16. SIGNATURE OF CLERK<br><i>John D. Smith</i>           |  |

1

RECEIVED  
JAN 15 1925  
BALTIMORE  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

10748

Reg. Dist. No.

10754

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamson</u> 75X-3  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>  |  |  |  | d. STREET ADDRESS <u>Williamson</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Williamson</u> Last <u>Snider</u>  |  |  |  | 4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1959</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>August 11, 1885</u>   |  |
| 9. AGE (In years lost birthday) <u>74</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>William T. Williamson</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Ellen Easton</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |  |
| 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>John H. Hornbaker</u>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute bacterial pseudocarditis</u><br>584X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Thrombosis &amp; Acute myopermyoma of</u><br>fall bladder (c) <u>Uncertain</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 days?</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <u>9/26, 1959</u> to <u>9-29, 1959</u> , that I last saw the deceased alive on <u>9/29, 1959</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>154 W. Washington St.,</u> DATE SIGNED <u>9:30:59</u> |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.   |  |  |  | PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u> <u>Hagerstown, Md.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>10/3/1959</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>White Church Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Zimmerman</u> ADDRESS <u>Shenandoah Rd</u>   |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>OCT 5 '59</u>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>  |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10772

10749

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chewsville</b>  |                               | c. LENGTH OF STAY IN 1b <b>3 years</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>Emma C. Strite Snyder</b> First Middle Last  |                               | 4. DATE OF DEATH <b>September 26 19 59</b> Month Day Year  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>March 15, 1883</b> |
| 9. AGE (In years last birthday) <b>76</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Leitersburg Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>John Strite</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Catherine Maun</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>203-10-1320</b>   |  |
| INFORMANT <b>I. Frank Snyder</b> Address <b>Chewsville Box 61</b>   |                               |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b><br><b>Years.</b> |                               |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Feb 25, 19 59</b> to <b>26 Sept 59</b> , that I last saw the deceased alive on <b>25 Sept 59</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.   |                               | ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown Md.</b> DATE SIGNED <b>9/28/59</b>  |  |
| ACTUAL SIGNATURE <b>J. D. Wilson</b> M.D.   |                               |  |  |
| PHYSICIAN'S NAME (Type) <b>J. D. Wilson</b>   |                               |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>9-29-59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Greenn Hill Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Waynesboro Pa.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Smithsburg Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>OCT 1 '59</b> DATE <b>24b. REGISTRAR'S SIGNATURE</b>  |  |

CERTIFICATE OF DEATH

0772

Greenville

South Carolina

September 10

1955

Interment in

Cemetery

101-10-110 I. Street, Greenville, S.C.

101-10-110 I. Street, Greenville, S.C.  
101-10-110 I. Street, Greenville, S.C.  
101-10-110 I. Street, Greenville, S.C.

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101-10-110 I. Street, Greenville, S.C.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10750

302

10773

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |   |   |   |  |
|--|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smithsburg R # 2</b>  |   | c. LENGTH OF STAY IN 1b<br><b>7 Yrs</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Smithsburg R # 2</b>                                 |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Itnyre Road</b>   |   |   |   | d. STREET ADDRESS<br><b>Itnyre Road</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>OSWALD</b> Last <b>SOWERS</b>   |   |   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>4</b> Year <b>1959</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept 23 1894</b> | 9. AGE (In years last birthday)<br><b>64 yrs.</b>   | IF UNDER 1 YEAR<br>Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>White Hall Wash Co Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Frank Sowers</b>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Bachtell</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>214-09-8634</b>   |   | 17. INFORMANT<br>Address <b>Mrs Alice J. Lyon Smithsburg Md R # 2</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis secondary to</b><br><b>162.1</b> DUE TO <b>Bronchogenic Carcinoma.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)   |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mos.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| None.  |   |   |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> o. m. <b>19</b> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br><b>119 North Potomac St.</b>   |   | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 12, 1959</b> to <b>Sept. 4, 1959</b> , that I last saw the deceased alive on <b>August 29, 1959</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>119 North Potomac St.</b> DATE SIGNED <b>9-5-59</b> |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>R.A. Bell</b>   |   | M.D. <b>R.A. Bell, M.D.</b> <b>Hagerstown, Maryland.</b>  |   |   |   |   |  |
| PHYSICIAN'S NAME (Type)  |   |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9/6/59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grind Stone Hill Cem. near Chambersburg Wash Co Md.</b>  |   | 22d. LOCATION (City, town, or county)<br><b>Penna</b>   |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>  |   |   |   | 24a. REC'D BY REGISTRAR<br><b>SEP 8 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. King</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1073

|                        |  |                        |  |                      |  |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                  |  |
| John Doe               |  | Male                   |  | 45                   |  |
| Date of Death          |  | Place of Death         |  | Cause of Death       |  |
| Jan 15, 1950           |  | Home                   |  | Heart Disease        |  |
| Time of Death          |  | Occupation             |  | Manner of Death      |  |
| 10:00 AM               |  | Teacher                |  | Natural              |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Coroner |  |
| [Signature]            |  | [Signature]            |  | [Signature]          |  |
| Name of Physician      |  | Name of Registrar      |  | Name of Coroner      |  |
| Dr. J. Smith           |  | John Doe               |  | John Doe             |  |
| Address of Physician   |  | Address of Registrar   |  | Address of Coroner   |  |
| 123 Main St.           |  | 456 Main St.           |  | 789 Main St.         |  |
| City                   |  | City                   |  | City                 |  |
| Baltimore              |  | Baltimore              |  | Baltimore            |  |
| State                  |  | State                  |  | State                |  |
| MD                     |  | MD                     |  | MD                   |  |
| County                 |  | County                 |  | County               |  |
| Baltimore              |  | Baltimore              |  | Baltimore            |  |
| District               |  | District               |  | District             |  |
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| Ward                   |  | Ward                   |  | Ward                 |  |
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10755

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>4 Yrs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1202 Hamilton Blvd</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>JEANETTE HELLER SOWERS</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>September 8 19 59</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Dec 23 1863</b>  |  |
| 9. AGE (In years last birthday)<br><b>95</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md. Clearspring Wash Co</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Eli Heller</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Kreps</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT Address<br><b>Mrs Aline Sowers 1202 Hamilton Blvd</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>420.0 DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Generalized arteriosclerosis with cerebral</b><br>DUE TO <b>bascular accident</b><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cataract</b> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH minutes<br><b>Indefinite</b><br><b>Indefinite</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>7 19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>19 52</b> , to <b>September, 19 59</b> , that I last saw the deceased alive on <b>September 7 19 59</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>9-9-59</b>   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.   |  |  |  | PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>9/10/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Pauls Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>near Clearspring Wash Co Md</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman Hagerstown Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>SEP 14 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hanna</b>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11928

10774

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. DITTO

MEDICAL CERTIFICATION

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>APPLETOWN - RURAL</u>  |  | c. LENGTH OF STAY IN TB<br><u>8 YEARS</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X APPLETOWN 'RURAL'</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>BOONSBORO MD. R12</u>  |  |   |  | d. STREET ADDRESS<br><u>1 BOONSBORO MD. R12</u>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HARRY</u> Middle <u>F.</u> Last <u>STOFFER</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>SEPTEMBER</u> Day <u>27</u> Year <u>1959</u>  |  |   |   |
| 5. SEX<br><u>MALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>JUNE-21-1901</u>   |   |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>6</u> Hours <u></u> Min. <u></u>                               |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LABORER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MEAT MARKET</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MAPLEVILLE WASH. CO. MD. U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u></u>   |   |
| 13. FATHER'S NAME<br><u>LYCURGUS STOFFER</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ROSA BETTS</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u></u>  |  | 17. INFORMANT<br><u>MRS. LEILA STOFFER</u>   |  | Address<br><u>BOONSBORO MD. R12</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Ch. Myocarditis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Active pleuritis</u> DUE TO <u>General</u><br>(c) <u></u>  |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u></u>   |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>  |  | 20f. (City or town) (County) (State)<br><u></u>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><u>A. E. W. Hitt</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |   |
| EXAMINER'S NAME (Type)<br><u>A. E. W. HITT</u>  |  | DATE SIGNED<br><u>9/28/59</u>   |  |  |  |   |   |
| 22a. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 22b. DATE THEREOF<br><u>SEPT. 30. 1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>BOONSBORO CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>BOONSBORO WASH. CO. MD.</u>                   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John H. Bast</u>   |  | ADDRESS<br><u>BOONSBORO MD.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>OCT 8 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur A. Kraus</u>  |   |

10775

WASHINGTON

WANDA-AND

DEATH OF - TOWNSEND, GUYMON -

DATE OF DEATH - 10-10-1914

PLACE OF DEATH - 1000 1/2 ST. N.W.

AGE - 35

SEX - F

CAUSE OF DEATH -

1. 2. 3.

4. 5. 6.

7. 8. 9.

10. 11. 12.

13. 14. 15.

16. 17. 18.

19. 20. 21.

22. 23. 24.

25. 26. 27.

28. 29. 30.

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>45 yrs.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1822 Gilbert Ave.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLIOT</b> Middle <b>HAMMOCK</b> Last <b>TURNER SR.</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>4</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 7, 1898</b>        |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ma chinist</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>W.M.R.R.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Shepherdstown, W.Va.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph D. Turner</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma C. Williams</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>705-10-4683</b>   |  |
| INFORMANT<br><b>Elliot H. Turner Jr. 1822 Gilbert Ave.</b>  |                                  | Address <b>Hagerstown, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) <b>general metastasis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 wks.</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Mar 9</b> , 19 <b>59</b> , to <b>Sept 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 27</b> , 19 <b>59</b> , and that death occurred at <b>8:45</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>217 W. Washington Street Hagerstown, Md.</b> DATE SIGNED <b>9-5-59</b>   |                                  |   |  |
| ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D. <b>217 W. Washington Street Hagerstown, Md.</b>  |                                  |   |  |
| PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D. Hagerstown, Maryland</b>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9/7/59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 8 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                                  |   |  |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10758

CERTIFICATE OF DEATH

10754

Reg. Dist. No.

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>   |  | c. LENGTH OF STAY IN 1b <u>1 MO 13 DAYS</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MD STATE HOSPITAL</u>  |  | d. STREET ADDRESS <u>1450 S CHARLES ST</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>HENRY</u> Last <u>WENDEL</u>  |  | 4. DATE OF DEATH<br>Month <u>SEPT</u> Day <u>26</u> Year <u>1959</u>   |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG 11 1897</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER HELPER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. |
| 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>PETERS WENDEL</u>   |  | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH VHK</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>220-14-3184</u> INFORMANT <u>EDWARD J. WENDEL</u> Address <u>3314 NOALE AVE</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u><br><u>581.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LAENNEC'S CIRRHOSIS</u><br>DUE TO (c) <u>CHRONIC ALCOHOLISM</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 DAYS</u><br><u>UNKNOWN</u><br><u>25 YEARS</u>                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>AUGUST 13, 1959</u> to <u>SEPT. 26, 1959</u> , that I last saw the deceased alive on <u>SEPT. 26, 1959</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>George Beru</u>  |  | ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE, BALTIMORE, MD.</u> DATE SIGNED <u>9/26/59</u>  |  |
| PHYSICIAN'S NAME (Type) <u>DR. GEORGE BERU</u>   |  | <u>HAGERSTOWN, MARYLAND.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 22b. DATE THEREOF <u>9-29-59</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM</u>   | 22d. LOCATION (City, town, or county) (State) <u>BROOKLYN MD.</u>                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Doppel Shoo</u> ADDRESS <u>7110 Belair Rd</u>  |  | 24a. REC'D BY REGISTRAR DATE <u>SEP 29 59</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thane</u>   |

MEDICAL CERTIFICATION

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THE MARSHALL ISLANDS GOVERNMENT  
MINISTRY OF HEALTH  
CERTIFICATE OF DEATH

NAME: JOHN HENRY  
AGE: 40  
SEX: Male  
DATE OF BIRTH: 11/11/1922  
PLACE OF BIRTH: BUA, MARSHALL ISLANDS  
DATE OF DEATH: 11/11/1962  
PLACE OF DEATH: BUA, MARSHALL ISLANDS  
CAUSE OF DEATH: HEARTIC FAILURE  
PERIOD OF ILLNESS: 24 HOURS  
SIGNATURE OF REGISTRAR: [Signature]  
DATE: 11/11/1962  
OFFICE: BUA, MARSHALL ISLANDS

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10775

## CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BEAVER CREEK - RURAL</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>  |  |  |  | d. STREET ADDRESS <u>HAGERSTOWN MD. R.I.</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HUBERT B. WINDERS</u>   |  |  |  | 4. DATE OF DEATH Month Day Year <u>SEPTEMBER - 30 19 59</u>  |  |  |  |
| 5. SEX <u>MALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>AUG. 15. 1896</u>  |  |
| 9. AGE (In years lost birthday) <u>63</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min. <u>7 15</u> |  | IF UNDER 24 HRS. <u>15</u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. Co. MD. U.S.A</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>GEORGE W. WINDERS</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARTHA KREBS</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I.</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>215-36-7210</u>   |  |  |  |
| INFORMANT <u>MRS. CHARLES W. MARTIN</u>  |  |  |  | Address <u>HAGERSTOWN MD. R.I.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>9-14-59</u> , 19 <u>59</u> , to <u>9-30-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-21-59</u> , 19 <u>59</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>10-2-59</u>   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> DATE SIGNED <u>10-2-59</u>   |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>OCT. 3. 1959</u>              |  | 22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. Co. MD</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. East</u> ADDRESS <u>BOONSBORO MD.</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>OCT 8 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>                              |  |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1972

WASHINGTON

HISTORIC

WHITE

ARMED

JOHN W. WILSON

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JOHN W. WILSON

JOHN W. WILSON

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

10759

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

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|--|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  |  |  | c. LENGTH OF STAY IN 1b<br><u>3 Days</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Wash county Hospital</u>  |                                  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>LUTHER</u> Last <u>WISHARD</u>  |                                  |  |  | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>30</u> Year <u>1959</u>   |  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 7 1903</u> |  | 9. AGE (In years lost birthday) yrs. <u>56</u> | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Truck Driver</u>   |                                  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hag Rescue Mission</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Cearfoss Wash Co Md</u>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                  |  |  | 13. FATHER'S NAME<br><u>John I. Wishard</u>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Alice M. Trumpower</u>  |                                  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates at service) <u>-----</u>   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>216-22-1648</u>  |                                  |  |  | 17. INFORMANT<br><u>Glenn Wishard 746 W. Wash St</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u><br><u>152.7</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> |                                  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arterio Sclerosis</u>   |                                  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |                                  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>               |  |
| 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>   |                                  |  |  | 21. I certify that I attended the deceased from <u>Syn 28 1959</u> to <u>Sept 30 1959</u> that I last saw the deceased alive on <u>Syn 30 1959</u> and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE<br><u>JH Beachley</u> M.D.  |                                  |  |  | ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>Oct 2 1959</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>JH Beachley</u>  |                                  |  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |  |  |
| 22b. DATE THEREOF<br><u>10/2/59</u>  |                                  |  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt Tabor Luth Cemetery Fairview Wash Co Md.</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Andrew K. Coffman</u>   |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 5 1959</u>  |  |  |  |
| ADDRESS<br><u>Hagerstown Md.</u>   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>  </u>  |  |  |  |

OCT 2 1959

Andrew K. Coffman

CERTIFICATE OF DEATH

10752

|                        |  |                     |  |
|------------------------|--|---------------------|--|
| NAME OF DECEASED       |  | JAMES H. HARRIS     |  |
| AGE                    |  | 45                  |  |
| SEX                    |  | Male                |  |
| RACE                   |  | White               |  |
| DATE OF BIRTH          |  | JAN 15 1903         |  |
| PLACE OF BIRTH         |  | BALTIMORE, MARYLAND |  |
| OCCUPATION             |  | DRIVER              |  |
| CAUSE OF DEATH         |  | HEART DISEASE       |  |
| MANNER OF DEATH        |  | NATURAL             |  |
| SIGNATURE OF PHYSICIAN |  | J. H. HARRIS        |  |
| SIGNATURE OF WITNESS   |  | J. H. HARRIS        |  |
| DATE OF DEATH          |  | JAN 15 1903         |  |
| PLACE OF DEATH         |  | BALTIMORE, MARYLAND |  |
| SIGNATURE OF REGISTRAR |  | J. H. HARRIS        |  |
| DATE OF REGISTRATION   |  | JAN 15 1903         |  |
| PLACE OF REGISTRATION  |  | BALTIMORE, MARYLAND |  |

(This form is to be filled out by the physician or other person who has attended the deceased, and is to be filed with the certificate of death.)

10760

## CERTIFICATE OF DEATH

10757

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>INGER</b> Middle <b>MARIE</b> Last <b>WOLFFSEN</b>  |   | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>3</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 25, 1897</b>                              |
| 9. AGE (In years lost birthday)<br><b>62</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Denmark</b>            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13. FATHER'S NAME<br><b>Julius Pedersen</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Thora Mortensen</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                      |  |
| 16. SOCIAL SECURITY NO.<br><b>215-14-1357</b>   |   | 17. INFORMANT<br><b>Mr. H.C.L. Wolffsen</b> Address <b>Box 104 Maugansville, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr</b>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>Feb 28, 1951</b> , to <b>Mar 6, 1959</b> , that I last saw the deceased alive on <b>Mar 6, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><b>Robert Vh Campbell</b>   |   | ADDRESS (Street, city or town, state)<br><b>145 W Washington St Hagerstown Md</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Robert V. L. Campbell</b>   |   | DATE SIGNED<br><b>9/4/59</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9/5/59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>SEP 8 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>   |   |   |  |

Wm. A. Host V-Pres.

10737

CENTRO-AMERICAN

10730

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Washington, D.C.  
February 1, 1937  
Dear Sir:  
Enclosed for you are two copies of a report on the results of the investigation of the case of the patient known as "John Doe" who was admitted to the hospital on January 15, 1937. The report is being submitted to you for your information and for your use in the case of the patient known as "John Doe".  
Very respectfully,  
John Doe

Enclosed for you are two copies of a report on the results of the investigation of the case of the patient known as "John Doe" who was admitted to the hospital on January 15, 1937. The report is being submitted to you for your information and for your use in the case of the patient known as "John Doe".  
Very respectfully,  
John Doe



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10758

10761

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b <b>3 Days</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>d. STREET ADDRESS <b>343 So Potomac St</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>ADA</b> First <b>LA MAR</b> Middle <b>YOUNG</b> Last<br>4. DATE OF DEATH <b>Sept 28 1959</b> Month <b>19</b> Day Year   |  | 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 16 1881</b> 9. AGE (In years lost birthday) <b>78</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (State or foreign country) <b>Wash Co Md</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>             |  | 13. FATHER'S NAME <b>Marene LaMar</b> 14. MOTHER'S MAIDEN NAME <b>Anna M. Snyder</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>218-38-1733</b> 16. SOCIAL SECURITY NO. <b>218-38-1733</b> 17. INFORMANT <b>Walter Young</b> Address <b>343 So Potomac st</b>                           |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br><b>420.0</b> DUE TO (Left ventricular failure)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b><br><b>3 years.</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchial Asthma.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |  | 21. I certify that I attended the deceased from <b>Nov. 5, 1956</b> to <b>Sept. 28, 1959</b> that I last saw the deceased alive on <b>Sept. 27, 1959</b> and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.   |  |
| ACTUAL SIGNATURE <b>R.A. Bell</b> M.D. <b>119 N. Potomac Street,</b> ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland.</b> DATE SIGNED <b>9-30-59</b>   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>9/30/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b> 24a. REC'D BY REGISTRAR <b>OCT 2 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| <p>NAME OF DECEASED<br/>                 [Faint text, possibly "John Doe"]</p>    |  | <p>AGE<br/>                 [Faint text, possibly "45"]</p>                                |  |
| <p>SEX<br/>                 [Faint text, possibly "Male"]</p>                     |  | <p>RACE<br/>                 [Faint text, possibly "White"]</p>                            |  |
| <p>DATE OF BIRTH<br/>                 [Faint text, possibly "Jan 15, 1910"]</p>   |  | <p>DATE OF DEATH<br/>                 [Faint text, possibly "Jan 20, 1955"]</p>            |  |
| <p>PLACE OF BIRTH<br/>                 [Faint text, possibly "Baltimore, Md"]</p> |  | <p>PLACE OF DEATH<br/>                 [Faint text, possibly "Baltimore, Md"]</p>          |  |
| <p>CAUSE OF DEATH<br/>                 [Faint text, possibly "Heart Disease"]</p> |  | <p>IMMEDIATE CAUSE<br/>                 [Faint text, possibly "Myocardial Infarction"]</p> |  |
| <p>INTERVIEWED BY<br/>                 [Faint text, possibly "Dr. J. Smith"]</p>  |  | <p>DATE OF INTERVIEW<br/>                 [Faint text, possibly "Jan 21, 1955"]</p>        |  |
| <p>SIGNATURE OF PHYSICIAN<br/>                 [Faint signature]</p>              |  | <p>SIGNATURE OF REGISTRAR<br/>                 [Faint signature]</p>                       |  |
| <p>OFFICIAL USE ONLY<br/>                 [Faint text]</p>                        |  | <p>OFFICIAL USE ONLY<br/>                 [Faint text]</p>                                 |  |



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND VITALS ACT, CHAPTER 10, SECTION 1-101, AS AMENDED.